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Fifty Years

THOMAS A. PITTS, M. D.
Columbia, S. C.

(This paper was presented at a banquet honoring Dr. Arthur Wolfe Browning of Elloree, S. C., upon the completion of fifty years of general practice.

In addition to paying homage to Dr. Browning, Dr. Pitts has presented a striking picture of the changes which have taken place in the field of medicine during the past half century. Editor)

For more reasons than one, I consider it a distinct privilege to be asked to do honor to so eminent a man in the practicing field of medicine. To begin with, my revered father gave his life in the same field, and from him I learned some of the greatest lessons medical ethics has to teach; from him I learned that the general practitioner's life is one of constant service night and day, from hut to mansion, in all kinds of weather over all kinds of roads. I learned that the "love of humanity" and the preservation of life called for a sacrificing and a forgetting of self.

But of this man whom we honor. What of him? I would like to draw a picture for you—a background to show him off as a graduate of the Baltimore Medical College in 1897—at the age of twenty-one, one of the youngest men in the class and with grades placing him near the top. Perhaps it was, in part, his boyhood days on the farm near Elloree that made him thus resourceful. No doubt these early farm days made him a lover of horses and laid the ground work for his excellence in the tilting tournaments of which he is justly proud. This farm boy life, too, fostered his love for dogs and hunting, for throughout his life he has been a Nimrod of note and one of the best wing shots in this area. His ability to train animals, both horses and dogs, is likewise noteworthy and it is agreed too, that he has always had a "way with the fair sex", a grouping that is not uncommon. I will not peruse this thought further as some things are better unsaid.

I don't know what the Baltimore Medical College looked like in that day nor what were the thoughts in that young man's mind as he stepped on the brink of his medical practice, but I know something of the times and you might be interested and even amused to remember some of the things and events of those days, if you too lived then, or to hear about them if you are of the younger fry.

He may have been decked in either a turtle-neck sweater or striped blazer and checkered trousers, if he were going bicycling, as this was the golden age of the wheel when it set the theme of the most popular song, "You'll look sweet upon the seat of a bicycle built for two". He probably included among his accessories, tight trousers, a high collar, sometimes rubber, and a derby hat. Lawn parties, box socials, and parlor games were good entertainment and the cake-walk was popular at dances as well as the waltz and the German. If he could, he went to the World's Columbian Exposition where he saw a burlesque and "Little Egypt'" do the hoochee-coochee.

Perhaps you might like to reflect on an era that had sugar for 4c a pound, eggs 14c a dozen, a turkey dinner at 20c, supper or breakfast for 15c, and men's box calf shoes at $2.50. The word "automobile" had yet to be coined. It was called the "horseless carriage" when treated seriously, and more frequently, the "devil-wagon", and the driver, "the engineer". Doctors had not heard of 606, or of insulin, and women doctors were looked on partly with ridicule. The general practitioner had to depend chiefly upon himself to diagnose and determine treatment. And, if he were in doubt, he did something palliative, for God is good—19 out of 20 will get well anyway.

With these remarks, we now meet our hero in his next role—that of general practitioner in a small town, Elloree. Population was still more rural than urban. The trend from farm to factory, from handicraft to mass production, from country to city, was beginning, which was to create new medical problems. His father's were of a different kind. The older gentleman had to saturate a rag with chloroform and put it in a teacup, holding it over the patient's nose while reducing a fracture or dislocation. Thermometers were yet to come into general use and a doctor had to get his bearings from a look at the tongue and by feeling

the pulse. Bandages were from old sheets and absorbent cotton was not sold widely. Bed pans had snouts on them and many could practice medicine all day if the calomel and quinine held out. But the doctor of the nineties and thereafter was confronted with kaleidoscopic changes. One fad after another would arise and be discredited. Do you remember the oxygenator and later, Abrahm's treatment? There were many other theories in vogue then that have long since been outmoded, even as the present ones will be in the future. To list some seems in order. Myasma was the poisonous vapor that drifted up from the swamps to cause fevers, and night air was certainly to be avoided. May-pops and yellow backed watermelons were the accepted cause of fevers. Inflammation of the bowel became typhalitis when Edward of England died of it; later it was called appendicitis from which surgeons of a later day grew rich and famous.

Membranous croup was one of the killers—no diptheria antitoxin was yet available. Locked bowels, continued fever, cholera infantum, milk fever and biliousness were real and sometimes hard to handle. Mothers chewed their food for their babies and more or less gracefully spat some of the premasticated food on their fingers and put it into the child's mouth. An asafoetida bag around the child's neck was used to prevent disease. Clothes were sewed on for the winter, and more student hours were spent on typhoid fever than any other one disease. The tonsil fad had not arrived.

Our young graduate met many strange things when he saddled his horse and threw across his back saddle bags that held most of the known armamentarium against disease. He knew a lot about botany and materia medica for these were the days when such was taught from books and in class and not, as is now the case, by drug salesman and detail men.

When Doctor Arthur Wolfe Browning came to Elloree in June 1897, he had seen six appendectomies in Baltimore while in college, but he soon found it necessary to assist at one performed on the dining table of the Bardin Hotel. He became expert in front porch operations, among them the amputation of a Negro's leg with the assistance of a farmer who gave the anaesthetic. This Negro still walks the streets of Elloree, doing all right with his homemade peg. Another was the case of the man who had been cut from chest bone to umbilicus, with intestines out through the wound. Doctor Browning washed them with saline and put them back and closed the wound. The patient's temperature never went over 100, and he came to the doctor's office about three months later to ask if he were going to live.

Doctor Browning has delivered more than four thousand babies, among them a two-headed child, a sixteen pound baby boy, three sets of triplets, several twins, all unassisted!

Some of his most trying times were during the period before and during World War I. There were epidemics of typhoid, colitis, malaria and hemorrhagic fever. During the War he served as chairman and examiner of the local board at Elloree. In the "flu" epidemic of 1918, he averaged over one hundred home calls a day for three months, not counting the patients that came to his office. He delivered over two hundred babies that year, all of this time still doing the local board work, and with weather so raw and cold that people had to bring their brass monkeys in every night.

He was President of the old Orangeburg County Medical Association, and drove horse and buggy to Orangeburg to attend the meetings, taking most of the day. Later he was President of the Edisto Medical Association. He has been on many State Medical Association Committees, and was selected to represent South Carolina at the first and second National Rural Health Conferences in Chicago, and the Southern Rural Health Conference in Chattanooga. He was on the Committee of Seventeen which worked so valiantly for the expansion of the Medical College at Charleston last year after their thorough and complete investigation.

It is men such as this who have made the phenomenal progress of medicine during the past fifty years possible. These benefits to mankind didn't just happen! These beloved practitioners of medicine of this time and before endeared themselves to the people by their devotion to duty and by strict adherence to the oath of Hippocrates, and placed our profession on a high plane, even above the calling of the cloth in the minds of a few. Now this position is being seriously undermined by selfish commercialism from within and by the socialistic propaganda from without which is sweeping the country. Physicians are disappearing from general practice. Students of the situation have predicted that the family doctor will disappear altogether from the American scene. I hope not. But the fact remains that there are fewer general practitioners today than there were fifty years ago. The country doctor, through his knowledge, ingenuity and courage has saved many lives. There are so many lessons for all of us to be learned at the feet of such pioneers in medicine. The high standards of our profession were built by them.

Under the stress and strain of modren life, the family physician, by which I mean the man with experience in general practice, is still the most valuable man of medicine to the individual, the family, the community and the nation. The investigators searching for clues to aid in the solution of the mystery of the vanishing physician, will find that the vogue for specialization has played the main role in the decline of the family doctor. There are American boards of this and that where entirely too much stress is placed on didactic training. Many such specialists are comparable to the aviator whose only training is

by correspondence and these 90-day wonders really charge.

There is a place and a need for the specialist but the general practitioner, due to his experience in treating all kinds of diseases, can never be replaced. For a practitioner gradually develops confidence as there is no one else to rely upon. It is he who should determine the need of a specialist, and in most instances, he is best fitted to select the specialist needed. The specialist tends to take more interest in the disease than in the patient who is the victim of the disease. A good family doctor never loses sight of the patient, but a specialist and his patient are usually strangers—he mistrusts him because he knows that a specialist, like a shoemaker, tends to stick to his last, his specialty. Most of you know this. At a certain medical school, specialists come regularly to lecture, and for material to illustrate the points they wish to make, they turn to the wards in the available hospital. Once a psychiatrist came to lecture, found in the wards a patient with a pronounced psychosis and used her as a text for his discourse. Later, a dermatologist found in the wards a sufferer from numerous skin lesions and used this patient to illustrate his points. Subsequently an expert on digestive disturbances selected a patient with persistent diarrhea, and since he had spent twenty years in China, the students made elaborate study of the stools to discover the cause. No one was struck by the coincidence that the patient who was used by each man, as an object lesson, was the same person, until a general practitioner, an old country doctor saw her and after a glance at her history said, "Why here you have something really remarkable, dementia, dermatitis, diarrhea. This woman has pellagra". This tendency to wear blinders, to see only his own field, is one of the specialists' handicaps. His achievements are the more remarkable because he struggles against so many of these handicaps, handicaps rooted in his own psychology, handicaps arising from his inevitable ignorance of his patients, handicaps arising from the fact that he knows his own field—or he doesn't! The increasing tendency towards specialization has led medicine to follow the example of industry—to establish a production line. The human chassis, on a belt conveyor, passes under the eyes of a regiment of specialists, and one does this, and another does that, each restricting himself to his particular field. and, like the mechanic who affixed the bumper and thought he built the car, each doctor, when the patient recovers, may secretly assure himself that he, and he alone, accomplished the cure.

Entirely too many are entering the special fields. If this trend continues, who is going to do the work? It is my honest and sincere judgment that there is no grander, no more self-satisfying work than that of the general practitioner. Doctor Frank Lahey, in an address to the Connecticut State Medical Society said, "There is no substitution for long hours and hard work. I think it is a misfortune that there is a tendency, it seems to me, to overlook the fact that long hours and hard work are the things that have built our characters and the characters of our parents".

It is the definite conviction of some of the outstanding leaders of the medical world that 80 to 85% of those seeking medical care could be skillfully and successfully cared for by a well trained general practitioner. The clamor for what the public calls "socialized medicine" is in truth a demand for cheaper medical care. This demand has a foundation of fact in that the cost of illness is most apalling. Few can afford doctors, hospitalization and nursing care for long illnesses. Some changes are inevitable. We know that "Government Medicine" is not the answer. Take the Veterans' Administration Hospitals. In Columbia, I am told, unofficially, the cost is between $17.00 and $18.00 per day per patient. The future county hospital may well be, of necessity, in the form of the general plan of the present day tourist camp. There could be a central medical station, with doctors, nurses and drugs, and the cottage occupied by patients with members of families doing much of the nursing, the dietary preparation and the laundry.

More physicians are needed in rural areas, but the truth of the matter is the medical graduate of today is unfitted to practice in small towns and rural districts as he is dependent on consultative services and on the help of laboratory technicians and other experts. Here is a remedy: in addition to the year of interneship, the medical graduate should practice, as an associate, with an established doctor, in a small town or rural community. In this way, he would gain, as under the old apprentice system, an understanding of his patients and experience in bedside practice that would be invaluable to him the rest of his life. It may be that after this, he should come back to take the State Board examination, and the examination should include questions on that experience. Such a plan would result in a more even distribution of practicing physicians between urban and rural communities. It is likely that many of these men would stay in the communities which they had served for a year, and no physician should be permitted to specialize until he has experienced five years of general practice.

It is not the purpose of this paper to contend that medical care in all rural areas is sufficient, nor to imply that specially trained physicians and large medical centers are not necessary. They are essential for any system of medical care. There are many improvements that can be made in rural medical practice and organized medicine should assist in better service. There should be provided, (1) better and more public health facilities; (2) more and better general district hospitals; (3) a maternity center for every county in the State; (4) at least one medical technician for each county; (5) a tuberculosis hospital for each district; (6) better roads for all the people; (7) the prepayment plan of hospitalization for all the people for all types of illness; (8) State Hospital for Cancer; (9) a

large medical college to supply the needs of the State.

Some parts of this program would, no doubt, call for enlistment of federal aid. If so, it must be operated under local control. Under the program outlined above, and with the vast store of scientific knowledge at his command, the general practitioner need have no fear as to his future role in medicine. And he can teach the specialist to temper his knowledge with love of humanity; to put his emphasis on the patient and make science serve his ends.

At the turn of the century, when Doctor Browning began practicing, there was no such intricate webbery of complexities in society. European proletarianism had not made inroads into the American School of thought, especially the professional school. Commercialism, collectivism, and socialism were not major factors. The dollar mark was not the American insignia, bargaining was not collective—the individual counted. The professional man dreamed of a "high calling" and as his dream crystalized, it became a "magnificient obsession" that climaxed in making him the benefactor of mankind at large. Such a calling has been that of Doctor Browning. Doctor Browning is typified by Robert Louis Stevenson—"There are men and classes of men that stand above the common herd; the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarelier still, the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilization; and when that stage of man is done with, and only remembered to be marvelled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Herculean cheerfulness and courage. So it is that he brings air and cheer into the sick-room, and often enough, though not so often as he wishes, brings healing".

And, quoting Sir William Osler, "And, finally, remember that we are useful supernumeraries in the battle, simply stage accessories in the drama, playing minor, but essential parts at the exits and entrances, or picking up, here and there, a strutter, who may have tripped upon the stage. You have been much by the dark river, so near to us all—and have seen so many embark, that the dread of the old boatman has almost disappeared, and

> When the Angel of the darker Drink
> At last shall find you by the river brink,
> And offering his cup, invite your soul,
> Forth to your lips to quaff—you shall not shrink:

your passport shall be the blessing of Him in whose footsteps you have trodden, unto whose sick you have ministered, and for whose children you have cared".

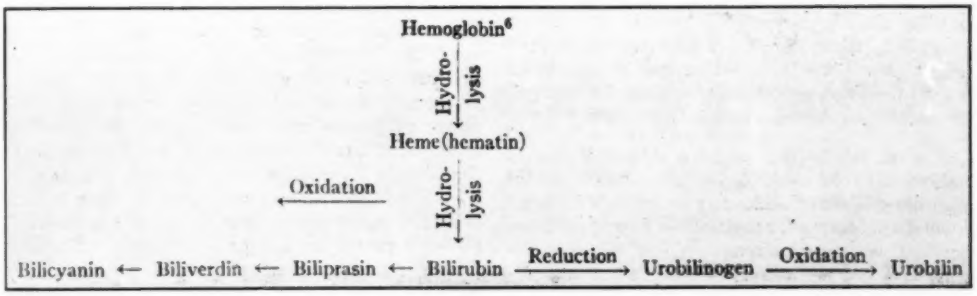
Again I say, with all sincerity, I deem it a happy privilege to honor a man who has the esteem and love of so many of his own profession, as well as the hundreds and hundreds who call him, "my doctor",—Doctor Arthur Wolfe Browning.

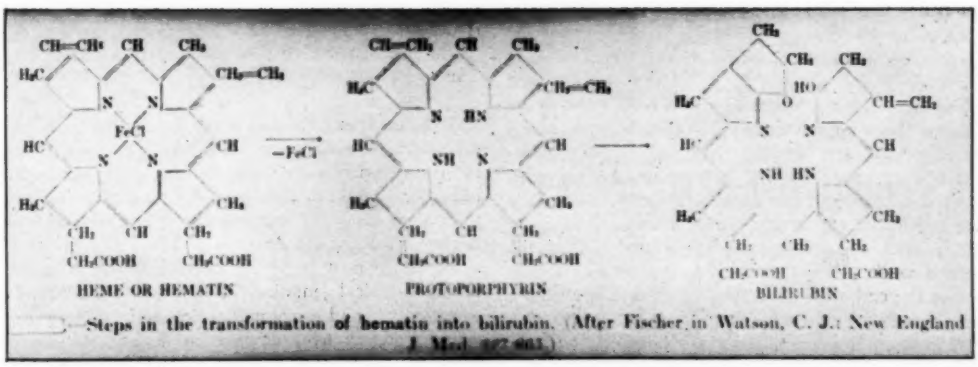
Physiopathological Discussion of Jaundice in Early Life

M. W. BEACH, M. D. AND CLYDE D. CONRAD, M. D.
Charleston, S. C.

Jaundice may be defined as an abnormal retention or regurgitation of bilirubin in the blood of sufficient quantity to stain tissue cells with a visible yellow coloration or to increase the bilirubin in the blood serum 2 or more milligrams per cent.

That we may have a clearer understanding of jaundice, it may be worthwhile to briefly review the formation of bilirubin. When the red cells are damaged or disintegrated they are taken up by the phagocytic cells of the reticulo-endothelial system and the hemoglobin is broken down to its constituents, globin and heme. The globin is initially split off by hydrolysis. This leaves several molecules of heme or hematin. The iron is then removed from the heme, leaving the coloring pigment protoporphyrin. This molecule is then split at the a-methene bridge and two hydroxyl groups are added to the carbon atoms formerly joined by the methene bridge. The resulting molecule is bilirubin.





Steps in the transformation of hematin into bilirubin. (After Fischer in Watson, C. J.: New England J. Med. 227:603.)

This product is carried to the liver for further synthesis. The byproduct is excreted into the intestinal tract as bile, where it is reduced or oxidized, partially reabsorbed for further synthesis, or is excreted in the feces or urine. The reduction of bilirubin forms urobilinogen or stercobilinogen which, when oxidized in the feces or urine, becomes stercobilin or urobilin. Normally, the adult daily excretes from 40 to 280 mgs. of urobilinogen in the feces and from 0 to 3.5 mgs. in the urine. During infancy and childhood, Josephs gives the following figures for fecal excretion of this product: first year, 13-30 mgs.; one to two years, 22-42mgs.; three to five years, 31 to 50 mgs.; and six to twelve years, 82-88 mgs. Since the liver is functionally concerned with all types of jaundice, we believe that it may be worthwhile to refresh our minds of its

multiple and complex physiologic functions before proceeding further with this discussion. We should recall that the liver is the largest organ of the body with a reserve of 80%. That the functional cells have marked regenerative properties and play a major role in the metabolic synthesis of carbohydrates, fats, proteins and vitamins. That it has to do with blood formation in the embryo and hematinic principles in the adult. That the liver produces fibrinogen, prothrombin, heparin and the blood serum proteins—albumin and globulin. That it stores copper, iron and glycogen. That it plays a role in the regulation of the acid-base balance, the heat production and the blood volume. That the liver acts as a detoxification center, secretes bile and excretes bile pigment. Therefore, any damage of this organ severe enough to cause clinical jaundice may alter, suppress or materially interfere with one or more of its complex physiological functions.

We have mentioned some of the liver's normal functions and have attempted to trace the normal sequences in the production of bile pigment, its synthesis in the liver, its excretion into the intestinal tract, its reduction and reabsorption, and its oxidation and excretion in the feces or urine.

All of us realize that jaundice is only a clinical manifestation of some physiopathological process which has progressed sufficiently to interfere with the normal detoxifying and excretory function of the liver. Therefore, we should attempt to find the causative agents and the mechanism responsible for this abnormal discoloration of tissue cells. In so doing, it may be worthwhile to consider the more common conditions of infancy and childhood that present jaundice as an outstanding clinical entity. It is with the newly born infant that we make our first acquaintance with jaundice and usually think little of its occurrence when seen on the second or third day, particularly if it appears to be mild in nature. But when there is early progression of a severe nature we become more apprehensive. The question then arises whether we are dealing with a simple icterus neonatorum, physiological icterus, or are we confronted with one of the more serious conditions. We are aware that the former causes little disturbance to the patient and disappears before the end of the second week, while the latter may terminate fatally before the end of the first week. Therefore, we should be conversant with the other common entities that may produce jaundice in the newly born.

With this idea in mind, we should give some thought concerning the possibility of the opposing Rh factors and different blood groups in expectant parents and should be mindful of the possibility of the mother having been transfused with blood which contained the antigens necessary to form certain hemoagglutinins. It is now customary for hospitals and most obstetricians to determine the Rh factor and blood type of the expectant mother. This is very valuable advance information which, if used conservatively, may prevent catastrophe to mother and offspring. This information forewarns the doctor and he should set in motion such procedures as may be necessary to cope with the expected newly born baby.

If the mother is a primipara, has a negative Rh factor in her blood and the father has a positive Rh factor in his blood, the fetus may be of the normal or of the erythroblastic type. If the mother's blood is free or has a low titer of agglutinins during the last months of pregnancy, the chances are that the fetus will be normal and may have little or no jaundice. However, during the second or any subsequent pregnancy, by the same husband, the mother usually shows a rising titer of agglutinins in her blood during the last trimester of pregnancy and may give birth to a viable or nonviable offspring. Here the newly born may be jaundiced at birth, or it may develop during the first few days. The intensity of the jaundice increases rapidly and the patient becomes more icteric, listless, toxic, dehydrated, acidotic and soon passes out of the picture unless prompt and efficient measures are instituted in an effort to overcome this medical emergency. A similar picture may occur in the offspring of parents who have positive Rh factors in their blood, but who differ in the A - B blood types, the infant's blood type being different from that of the mother. When jaundice is seen in these infants, it usually occurs a little later and is of less intensity, but may persist for two or more weeks. Congenital hemolytic anemia occasionally may be seen during the early weeks of life, and when it occurs produces a severe degree of anemia and jaundice. Also, sickle cell anemia is quite rare during the early days of life, but some cases have occurred during the neonatal period. Malformation or atresia of the bile ducts should be considered as a probable cause for the production of jaundice during the early weeks of life. This is a progressive, intensive type of jaundice.

Syphilis, hemolytic and viral infections should receive due consideration. Expectant mothers often receive ante-partum transfusions which may act as the nidus for a viral infection in mother and offspring and thus cause an acute hepatitis which produces various degrees of jaundice. As time goes on, the infant is subjected to many types of infection, some of which produce clinical jaundice. The indiscriminate use of certain drugs and sometimes accidental poisoning may cause sufficient liver damage to disrupt its normal function and thereby produce a clinical icteric state. During childhood, occasionally we may see jaundice which is a part of the clinical picture of cirrhosis of the liver, or associated with neoplasms in or adjacent to the liver. Also, cholecystitis and cholelithiasis are seen in congenital hemolytic anemia in white children and sickle cell anemia in negroes. Parasitic infections should be mentioned, but are rare causes of obstructive jaundice. Severe jaundice encountered during early life is most likely a manifestation of one of the following conditions:

1. *Icterus neonatorum severus.* In our consideration of this form of jaundice, we wish to call to your attention that we are attempting to present a clinical entity somewhat different from the ordinary case of physiological jaundice which is thought to account for 98% of all icteric states seen in the newly born baby. This form of jaundice, when it occurs in the normal mature infant, is ordinarily clinically evident by the second, third or fourth day. It is mild in nature, moderate in intensity, of short duration (less than two weeks) and produces a mild discoloration of the skin liken unto the yellow tint of a peach. There is little or no constitutional disturbance. The blood findings, other than an increased amount of bilirubin, are similar in character to those who do not show jaundice. On the other hand, the cases which we have designated icterus neonatorum severus develop their icteric states on the first, second, or third day of life. It is severe in nature, progresses rapidly for several days, the discoloration of the skin is intense and of a greenish-yellow tint. The constitutional symptoms develop early. The infant soon loses the desire to nurse, takes fluids only when forced and often vomits, becomes listless, drowsy, dehydrated and toxic. The stools are large, first meconium, then greenish-yellow, normal in number and in character. The urine is highly colored and may be positive for bilirubin and urobilin. The blood picture differs from that of the normal infant in the rapid and progressive destruction of the red blood cells with a rather high retention of bilirubin in the blood, the van den Bergh is usually biphasic. The temperature fluctuates a little above and below normal. There is an increased weight loss, slow convalescence and the jaundice usually persists for several weeks. These infants are born to parents whose blood contains the Rh positive factor, but usually have a different A, B and O group from that of their offspring. Whether these or some other factors are the crux of the explanation for the severe type of hemolytic jaundice, icterus neonatorum severus, which we have attempted to describe, will be answered by further clinical study and research.

Now we will present two case histories which may give you a better clinical picture of this phase of jaundice.

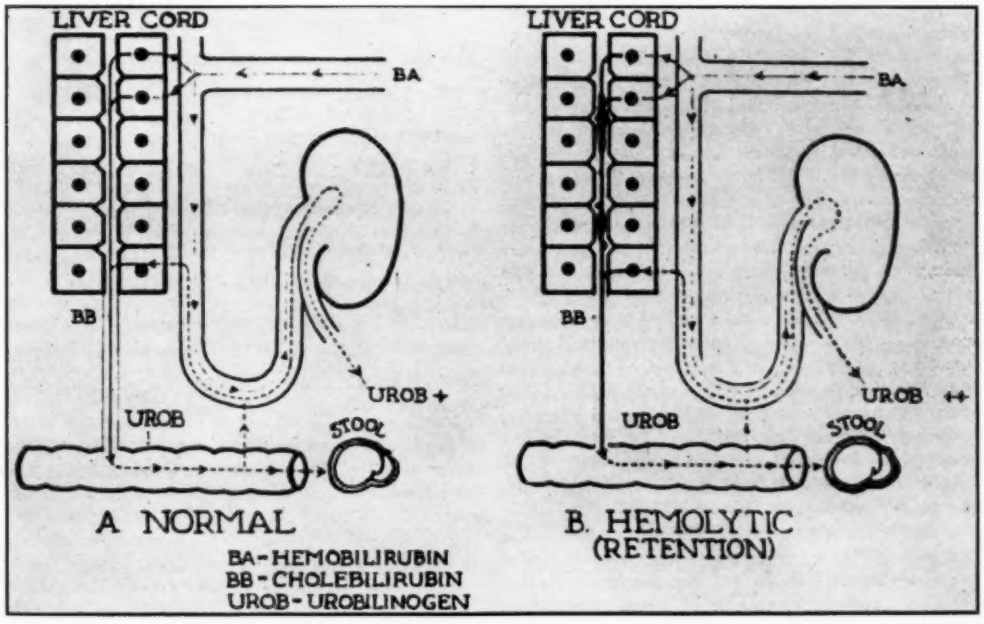
Case Number One.

Chief Complaint: Severe jaundice, vomiting, listlessness.

Present Illness: This newly born appeared to be doing well until the end of the second day, when she developed jaundice which increased in intensity during the following three or four days. She refused the breast and fluids, vomited several times and had two or three green, loose stools. She soon became listless and drowsy and showed evidence of dehydration.

Past History: White female. Full-term, normal, spontaneous delivery. Birth weight was 8 pounds and 2 ounces. The third offspring.

Family History: The mother has always enjoyed good health and has never had any serious illness. The father is living and well. Mother's Wassermann is



negative. She has an Rh positive factor in her blood.

Physical Exam.: This revealed that the patient was a well developed and nourished infant who had carried on in the normal manner for the first 48 hours. She appeared drowsy, listless and showed evidence of dehydration and intoxication. The jaundice was very intense and the general appearance was that of a seriously ill newly born baby. The temperature graph was slightly above and below normal. Respiratory and cardiac rate was increased. Otherwise, the physical examination was noncontributory.

Lab. Exam.: Mother's blood has an Rh positive factor. Wassermann is negative. Blood group B. Baby's blood is Rh positive. Blood group AB. Icterus index 187 units. Van den Bergh, indirect ++++; direct ++. Urine positive for bilirubin and urobilin. Stools showed an increased amount of bile pigments. There was a fairly rapid destruction of red cells, more than a million per cubic millimeter in three days, but the total red cell count did not fall below four million per cubic millimeter.

Treatment: The patient was immediately hydrated with isotonic solution of sodium chloride and glucose. The nurse was instructed to administer one-half ounce of this solution between feedings. The baby's formula consisted of a high protein, high carbohydrate and low fat mixture.

Discussion: The infant passed a large amount of meconium for three days, then the stools became green and slightly loose for two days, and soft yellow thereafter. The weight loss was rather marked during the first twelve days and she did not regain her birth weight until the nineteenth day. The parenteral administration and the forcing of fluids was necessary to cope with the toxic, dehydrated and acidotic state. After she had received sufficient fluids and electrolytes, her general condition slowly improved, but the severity of the jaundice remained about the same until after the tenth day. Then it slowly subsided during the following two weeks. The infant did not recover of the icteric state nor make normal progress until the fourth week. We believe that it may be logical to explain her van den Bergh and urinary findings on the basis of excessive production of bilirubin and the inadequacy of the fetal liver cells to take on their normal function whereby this pigment may have been excreted into the intestinal tract. According to Rich, it is reasonable to assume that with a marked increase of bile pigment carried to the liver for further synthesis and excretion, there is a probability that with this increased engorgement some of the liver cells may break down and release bile salts into the lymphoid channel and thence into the general circulation. This would explain the direct van den Bergh reaction. We have encountered in the pediatric and new-born services several cases similar to the one reported above. The question arises whether we should consider this a case of severe physiological or an abnormal type of hemolytic jaundice due to one of the atypical hemoagglutinins set up by different blood groups in mother and offspring. Some authors believe that this is the most logical explanation for these abnormal icteric states seen in infants where mothers and offspring have such blood types as was found in this case. They believe that there is a possibility of these types of red cells acting as pro-antigen which sets in motion the formation of iso-agglutinins in the mother's blood and which may be transferred to the fetus and thereby cause agglutination and destruction of red cells, the severity of the jaundice being predicated on the time, titer and quantity of hemoagglutinins which have succeeded in passing into the fetal circulation.

Case Number Two.

Chief Complaint: Jaundice, anorexia, crying.

Present Illness: This newly born infant become yellow on the 7th day of life, and has gradually become more orange. Takes very little formula and cries continuously. Stools are yellow or green-flecked and urine is dark. Never vomits, nor has baby had diarrhea.

Past History: Full-term, spontaneous delivery, uncomplicated. Birth weight was 7 pounds, 12 ounces. Breast fed for 9 days, then put on formula for lack of breast milk. Has always nursed poorly.

Family History: Mother's Wassermann is negative. Rh factor not determined. Five previous pregnancies, the first 4 of which died at 2 or 3 weeks of age, and were jaundiced. The 5th child is alive and well at 3-years-of-age.

Physical Exam.:

Head: Fontanelles open and soft.

Ears: Membrane tympani pale and yellow.

Nose: Airway clear.

Eyes: Sclerae jaundiced. Pupils react to light.

Mouth: Normal mucosa. Tongue normal.

Neck: Supple. Thyroid normal.

Chest: Clear to percussion and auscultation.

Heart: Not enlarged to percussion. No murmurs. Rapid and regular. P2 greater than A2.

Abdomen: Soft and non-tender. Liver 4 cms. below right costal margin. Spleen not felt.

G. U.: Scrotum (?) bivalved. No testes present. Penis (?) (or large clitoris) with urethral orifice on under surface. No vaginal orifice.

Extrem.: Normal.

Reflexes: Physiological.

Skin: Intensely jaundiced. Moderately dehydrated.

Lab. Exam.: (On admission)

R. B. C.–5 million; hemoglobin–13 gms.; W. B. C. –14,300; differential–normal. Icterus index–108 units. Van den Bergh ++ direct; +++ delayed direct. Wassermann and Kline–negative. Fragility test–within normal limits. Stool–urobilin and urobilinogen present. Blood type "O". Rh factor positive. Mother's Rh factor positive.

Hosp. Course: There was a gradual fall in red blood cells and hemoglobin for 5 days and a sudden fall on the 6th day (to red blood cells–2.8 million; hemoglobin–7 gms.) with sudden circulatory collapse and air hunger. Required venesection and immediate transfusion, followed by repeated small transfusions and maintenance of hydration. Gradual loss of jaundice and decrease in the size of the liver until the twelfth hospital day, when there was a sudden onset of Cheyne-Stokes respirations and lethargy without other clinical evidence of intracranial hemorrhage. Red blood cells were 4 million; hemoglobin 12 gms. Icterus index was 20 units with van den Bergh reaction unchanged.

Comment: Oxygen, stimulants and artificial respiration failed to restore normal breathing. Died on the twelfth hospital day. Clinical cause of death–kernicterus.

Final Diagnosis: (By autopsy)

1. Female baby, shown by uterus, tubes and ovary with imperforate vagina.

2. Interstitial pneumonia.

3. Strangulation of chorioid plexus with hemorrhage.

II. *Congenital obliteration of the bile ducts.* This malformation of the bile ducts is probably the result of an arrest in the development of the biliary ducts. There may be an absence or an early obliteration and cord-like formation, instead of the usually patent biliary ducts in which there may be an absence or an atresia of the hepatic ducts, an atresia or stenosis of the common duct, or various other malformations of this system. The jaundice in cases of biliary atresia during the first few days of life may present all the common ear marks that are found in the normal infant of a simple icterus neonatorum. On the other hand, some of these cases do not develop clinical jaundice until after the first week, but when the icteric state has become evident, it is without remissions and slowly increases in intensity and the skin assumes a greenish-yellow, bronze color which is commonly seen in cases of complete obstruction of the biliary tract. The constitutional symptoms are mild and the patient does not appear to be distressed and usually takes formula and fluids well. The stools are of the acholic type. The urine is intensely bile stained. The liver soon becomes enlarged and its firm, smooth edge can be palpated 6 to 8 cm. below the costal margin. Later, the spleen becomes enlarged. The van den Bergh test gives a direct reaction. The icterus index varies from 50 to 350 units.

These patients may survive for months, but when the diagnosis has been established and the general condition of the patient is satisfactory, an exploratory laparotomy should be performed because 20% of these patients have malformations which may be corrected by surgical means. However, the small number of cases that we have encountered were not amenable to surgery. We will report one of these case histories.

Case Number Three.

Chief Complaint: Jaundice of the progressive type; rash on face.

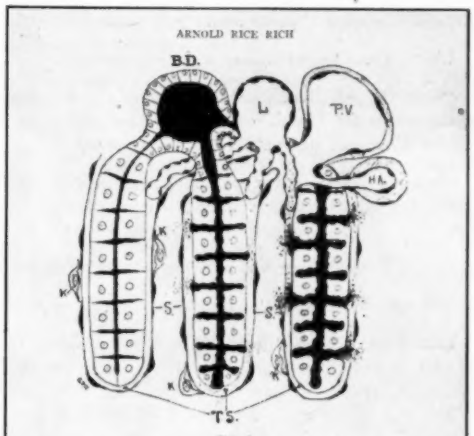


FIG. 2

B.D. = bile duct; L. = lymph vessel; P.V. = portal vein; H.A. = hepatic artery; T.S. = tissue space. S. = Endothelial lining of sinusoid. It will be noted that, contrary to text-book tradition, this endothelial lining is complete, and is formed of endothelial cells, not of the irregularly scattered Kupffer cells (K) as is often stated. Normally, the endothelium lies close against the liver cells, so that it is difficult or impossible to see it, but when the liver cells are atrophic (e.g., in chronic passive congestion) they tend to shrink away from the endothelium, and the complete lining of the sinusoids often becomes beautifully clear. The fact that in early obstructive jaundice bile pigment appears in the lymph earlier than in the blood stream is itself evidence that the tissue space is separated from the blood by a complete lining.

Present Illness: This seven-weeks-old white male infant is said to have been jaundiced at birth, which has steadily become more intense. Seldom vomits–nor is vomitus ever bile stained. Mild constipation. Stools are usually of normal color, but sometimes are chalky white. Has had rash on face for the past two weeks.

Past History: Full-term, forceps delivery. Birth weight was seven pounds and two ounces. Has gained weight–now weighs eight pounds and two ounces. Put on formula at age of four days because of sore breasts and inadequate supply.

Family History: Mother and father living and well. Veneral history negative. No abortions. One sibling of six years, living and well. Not jaundiced at birth.

Physical Exam.: This was a fairly well developed and nourished infant who had the facies of being unwell, but showed no acute distress. There was a fine, petechial rash on forehead and face.

Head: Anterior fontanelle open. Posterior closed. No abnormal findings.

Ears: Membranae tympani colored yellow.

Nose: No discharge.

Eyes: React to light. Sclerae intensely yellow. Some icteric color of tears.

Mouth: Mucous membranes icteric. Tongue coated. Pharynx clear.

Skin: Some petechial rash on face and forehead and the skin is intensely jaundiced.

Neck: Supple. Thyroid apparently normal.

Chest: Clear to percussion and auscultation.

Heart: Rapid. Regular. Apex beat in the 4th inter space inside the midclavicular line. First and second sounds clear and distinct. No murmurs noted.

Abdomen: Flat. Liver palpable four or five cms. below the costal margin. Spleen not felt. No masses felt.

G. U.: Normal. Testes in scrotum. No phimosis.

Reflexes: Physiological.

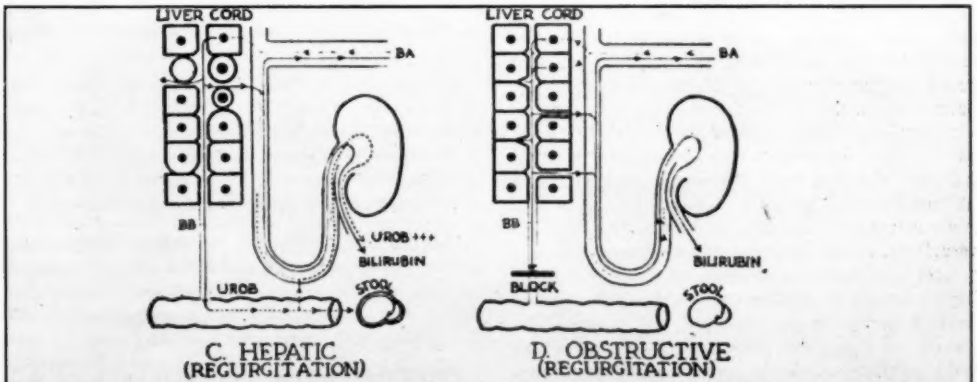
Lab. Exam.: Blood—R. B. C., 3.2 mil.; W. B. C., 14,050; hemoglobin, 8 gms.; P. M. N., 26; lymp., 62; mono., 4; eosin., 7; bas., 1; 1 nucleated RBC/100 WBC. Van den Bergh, direct ++-+; delayed direct ++++. Infant's blood type was IIA. Mother has Rh positive factor. Baby was Rh positive. Prothrombin time, bleeding time, coagulation, total and fractional serum proteins—all within normal range. Wassermann and Kline—negative. Feces—negative for bilirubin. Urine—negative for urobilin and urobilinogen; positive for bilirubin.

Hospital Course: Temperature varied from 99° to 100° before operation. Patient given transfusions of fresh blood, vitamins and vitamin K. Stools were pasty white, although occasionally stained on surface with yellow, questionably bile. During the pre-operative period, he gained eleven ounces. Exploratory laporatomy revealed that there was no demonstrable gall bladder nor bile ducts. The patient stood this operation poorly. The post-operative course was steadily downhill, with the jaundice increasing in intensity. He became toxic and vomited. Took fluids and food poorly after the operation and died on the fourth post-operative day.

Comment: This patient was a rather poor surgical risk, but on account of the possibility that he might be one of the twenty per cent which could be relieved by surgical means, the attending physician and surgeon felt that he should be given the benefit of an exploratory laporatomy.

Final Diagnosis: Congenital atresia of bile passages.

III. *Septicemia.* Since the advent of the sulfonamides, penicillin and streptomycin, there has been a marked reduction of sepsis in mother and offspring which is partially responsible for the decline of the icteric state encountered in this type of case. The most frequent etiological agents of these cases are: the streptococcus, pneumococcus, staphylococcus and the colon bacillus. These infections may occur prenatally or postnatally. Probably the most frequent portal of entry is through the cord and skin. These infants are acutely and seriously ill with high fever, rapid pulse and respiration, are drowsy, irritable and often refuse to nurse or take fluids. They soon become toxic, dehydrated and acidotic. The icteric state in these cases adds to the gravity of the situation. However, with the present day therapy of the sulfonamides and anti-



—Schematic drawing explaining the changes of the bile pigment metabolism in the various forms of jaundice (Steigman, T., Popper, H., and Meyer, K. A., J.A.M.A. *121*.)

botics and a better understanding of the importance of fluids and electrolytes, blood and plasma, and improvement in the technique of administration, we may now rescue some of these helpless individuals.

IV. *Congenital Syphilis.* This tragedy of the newly born infant in which jaundice, anemia, edema and osteochondritis are the predominating symptoms is less frequently encountered than in former days. However, we should always be mindful of the possibility of this disease and of its bizarre manifestations, which may be very similar to other icteric states encountered in the infant during its early days of life. It may cause confusion and simulate sepsis, biliary dysfunction, erythroblastosis, etc. These types of cases usually occur of pregnant mothers who have a severe syphilitic infection and who have received no anti-syphilitic treatment, or received treatment very late in pregnancy. Since this form of jaundice presents such a variegated pattern, we will attempt to cover a portion of its vagaries with a case report.

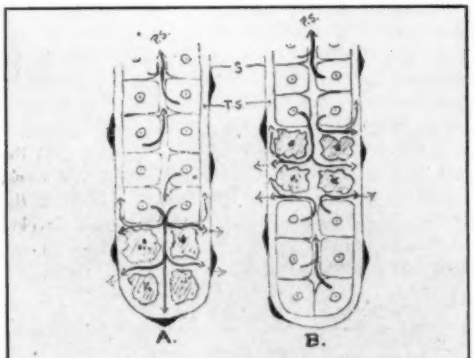


FIG. 1

T.S. = tissue space; S. = Endothelial lining of sinusoid; P.S. = Direction of bile duct in periportal space. The arrows indicate the manner in which bile is regurgitated into the tissue spaces and blood stream when the canaliculi are ruptured as a result of necrosis of the hepatic cells. A shows the condition in central necrosis, B in midzonal necrosis. —REICH—

Case Number Four.

Chief Complaint: Jaundice; discharge from nose; swollen scrotum.

Present Illness: This six-weeks-old colored male infant took sick two or three days ago with fever, fretfulness, discharge from nose, yellowish color of skin and swelling of scrotum. Stools normal in number and yellow in color.

Past History: Full-term, normal, spontaneous delivery. Birth weight was seven pounds. The neonatal period was uneventful. Breast and bottle fed.

Family History: This was the mother's first pregnancy. No difficulties and has enjoyed good health. The father is in good health and has never had any sickness. Both denied all veneral diseases, but have never had blood test.

Physical Exam.: Acutely and seriously ill infant who is cross and irritable and refuses to lie in the supine position.

Head: Anterior fontanelle open and full; posterior closed.

Ears: Negative.

Eyes: Pupils react to light. Sclerae yellow.

Nose: Seropurulent discharge.

Mouth: Clean. Mucous membranes pale with yellow cast.

Neck: Thyroid normal.

Chest: Fairly well aerated. Few mucus rales throughout the two sides.

Heart: Apex beat in the 4th inter space inside mid-clavicular line. First and second sounds clear and distinct. No murmurs noted.

Abdomen: Liver enlarged and palpable 3 cms. below the costal margin. Spleen palpable at costal margin.

G. U.: The right side of scrotum was enlarged, edematous and slightly ulcerated.

Extrem.: Appeared to be normal.

Reflexes: Physiological.

Skin: Dry and intensely jaundiced.

Lab. Exam.: (On admission)

W. B. C., 3,200; R. B. C., 1.24 million; hemoglobin, 3.75 gms. There was no sickling of red blood cells. Icterus index was 142 units. Van den Bergh was ++++ direct. Rh factor of mother and child were positive. Mother's and father's Wassermann and Kline were ++++. X-ray of long bones showed no evidence of syphilis. Spinal fluid Wassermann was positive ++++, and contained 2,328 cells with 95% polys. Total proteins 190 mgs. Sugar 15 mgs. Two spinal cultures negative.

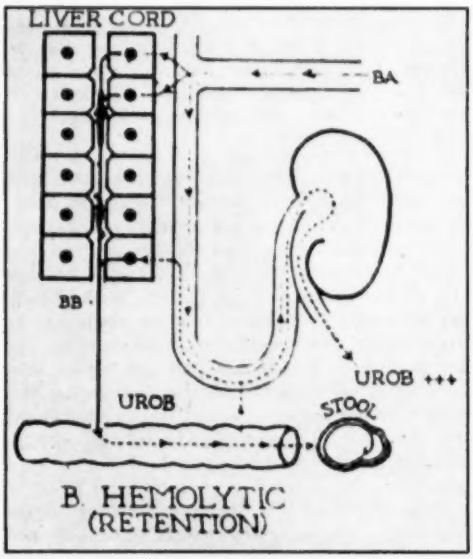
Hospital Course: The infant was transfused with blood and given penicillin therapy. His general condition improved and he was less irritable. Jaundice was less intense and in nine days the icterus index had dropped to 22 units. On account of the continuance of the high cell count and high proteins in spinal fluid, some meningitis other than syphilis was thought to be present. Spinal culture continued to be negative. The temperature was 99° to 103° for 2½ weeks, then slowly subsided to normal. Treatment during this period included sulfadiazine and dicumerol therapy. After this time, he was placed on anti-syphilitic regime. He also received accessory food factors. After thirty days of hospital treatment, there was no evidence of jaundice. The liver was only 2 cms. below costal margin. Hemoglobin and R. B. C. had returned to normal. Other than positive Wassermann and Kline,

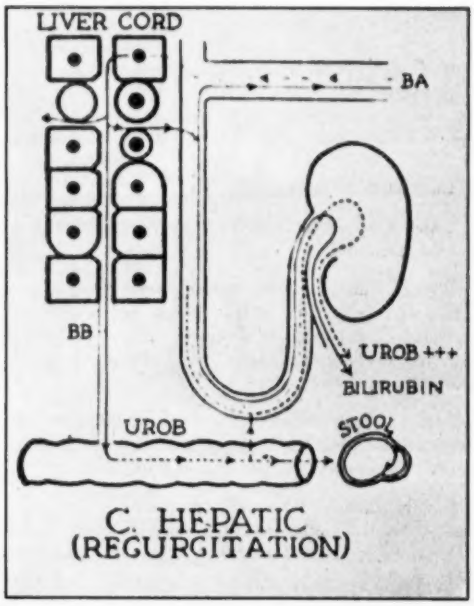
the spinal fluid was normal. The blood Wassermann and Kline continued to be positive.

Final Diagnosis:

1. Congenital syphilis.
2. Syphilitic hepatitis with obstructive jaundice.
3. Anemia, severe, secondary.
4. Meningitis, type undetermined.

V. *Erythroblastosis foetalis.* This clinical entity in which jaundice, anemia and sometimes edema, singly or combined, present the hall-mark for the most serious and fatal hemolytic disease encountered in the newly born infant. Most infants are very fortunate on account of the low incidence of this grave type of jaundice. Only one occurs in every two or three hundred births. However, these figures vary greatly in different communities. Even though the incidence is low, the mortality is more than 50%. Therefore, we should anticipate the seriousness of these icteric states which may occur in some of our newly born babies whose parents have not had the advantage of blood study. To Landsteiner, Wiener, Levine and others goes the credit for the scientific work and clinical application whereby 90% of these forms of jaundice may be classified according to their etiology. However, there is still a missing link and 10% of these cases are without adequate explanation in which the mother may be Rh positive, or the baby Rh negative, etc. Therefore, it is now conceded that in most instances erythroblastosis foetalis in all of its forms, and there are many, is based upon the immunization of the Rh negative mother by the Rh positive red cells of the foetus or by previous transfusion with this type of cell. Most of the expectant mothers react to these antigens and produce a soluble anti-agglutinin which passes into the foetal circulation and there causes agglutination and destruction of red cells. The resultant jaundice is dependent on the time and amount of agglutinins produced in the mother and when the foetal circulation becomes susceptible. The mother's response to this antigen varies considerably and some do not respond at all. Therefore, the different types of response encountered in mothers may be the factor responsible for the marked variance of symptoms seen in this disease. In the grave form the pattern is dominated by a general anasarca which appears to be puffy and pitting in nature and extremely marked about the eyes, lips and face. The abdomen is distended and often tense. The skin is edematous, lacks continuity and is of a greenish-yellow color. The anemia is of sufficient grade to speed up the respiratory and cardiac response. The heart is enlarged and presents various types of murmurs. The liver and spleen are very much enlarged and are resistant to palpation. There is a sub-normal response of the patient to the examination and the examiner is impressed by the gravity of the situation. The erythrocyte count and hemoglobin are about one-third of the normal. There are frequently more than 10,000 nucleated red cells, also a large number of reticulocytes. The platelets are generally reduced in number, the bleeding time is prolonged. The prothrombin may be deficient. The van den Bergh is biphasic and the stools may become clay colored during the first week, should the patient survive. On the other hand, if the edema is absent and the jaundice and anemia develop more slowly in the first few days of life, the infant's chance of survival is increased very much. Of course,





this statement is somewhat predicated on the efficiency and promptness in which we meet this medical emergency. In further consideration of this icteric state, we believe that it may be worthwhile to impress the physician with the accumulated evidence which suggests that there are many types of erythroblastosis foetalis of varying degrees of severity and that the greater majority present a more favorable picture and some recover with meager or without treatment.

We have attempted to refresh your minds with certain data pertinent to this form of jaundice and now will present a clinical case which somewhat conforms to the latter group.

Case Number Five.

Chief Complaint: Severe jaundice anticipated.

Present Illness: Newly born white female infant weighing 7 pounds, 4½ ounces. Born of parents with known Rh factor incompatibility. Full-term, spontaneous delivery in hospital January 31, 1947, the patient being closely observed for possibility of erythroblastosis fetalis.

Family History: The mother is 42-years-of-age. She is Rh negative. The father is Rh positive. Seven living children, 2 abortions and the last 5 infants were born alive, but died with jaundice. Excluding 2 abortions, said to be due to malaria plus medicine and fall on abdomen in that order of gestation, the past 5 pregnancies produced infants who developed jaundice on the third day of life and died in 3 days, 6 days, 5 days, 16 days and 3-months-of-age respectively in the order of birth. Mother's anti-Rh factor agglutinin level followed during the last 6 months of this pregnancy was as follows:

9/ 7/46 positive 1-4 dilution

11/ 8/46 positive 1-16 dilution

1/ 4/47 positive 1-4 dilution

1/31/47 positive 1-1 dilution (about 7 hours before delivery).

2/24/47 negative in all dilutions (about 3½ weeks after delivery).

Mother's veneral history is negative and Wassermann and Kline is negative. Mild toxemia of pregnancy with last 5 pregnancies and with this one, as evidenced by blood pressure of 142/70 to 160/100, vertigo and 7 to 10 pounds weight gain during the last month before delivery. No albuminuria or edema at any time with this pregnancy. Seven siblings, living and well; 26 years, 24 years, 21 years, 16 years, 13 years, 11 years and 8 years of age.

Physical Exam.: Apparently healthy, newly born female infant, without jaundice. Temperature 98° F. Both fontanelles open; not bulging. Head 13½" in circumference, shoulders 14½", chest 14", length 18½".

Ears: Normal.

Nose: Normal.

Eyes: Sclerae easily seen and not jaundiced. Pupils react to light.

Mouth: Mucous membranes pink. No hemorrhage. No malformations.

Neck: Supple. Thyroid apparently normal.

Chest: Clear to percussion and auscultation.

Heart: Rate rapid and regular. No murmurs. Apex beat inside midclavicular line.

Abdomen: Flat. Not distended. No bleeding from cord. Liver palpable under costal margin. Spleen not felt.

G. U.: Normal female.

Extrem.: No deformities. Nails good color.

Reflexes: Physiological.

Lab. Exam.: (First hospital day)

R. B. C., 4.37 million; hemoglobin, 17 gms.; W. B. C., 17,300; polys., 61, lymph., 36; mono., 3. Eight normoblasts per 100 W. B. C. Reticulocytes 12%. Normocytic, normochromic. Blood type A. Rh factor determination positive. Anti-Rh factor agglutination titre negative in all dilutions. Urine dark orange yellow. Kline negative. Patient matched and crossmatched with Rh negative donor; no blood given. Patient given vitamin K, mgms. 5 daily for 3 days. No breast feeding permitted. Placed on formula of evaporated milk, 6 ounces, 2 tablespoons Karo syrup, boiled water, 9 ounces, given in 6 feedings daily.

Hospital Course:

Second hospital day—R. B. C., 4.30 million; hemoglobin, 17 gms.; W. B. C., 15,500; polys., 61; lymph., 36; mono., 3; normoblasts/100 W. B. C., 0; Reticulocytes, 6%. Normocytic, normochromic. Weight 6 pounds and 15 ounces. Patient developed a slight icteric tint to sclerae. Passed one meconium stool. Liver 2 cms. below costal margin. Spleen 4 cms. below costal margin. Given 60 cc. transfusion of Rh negative blood, and 75cc. of 2½% dextrose in half normal saline subcutaneously.

Third hospital day—Hemoglobin, 16 gms. Patient intensely jaundiced, vomited most of every feeding, passed three meconium stools and was silghtly distended. Karo in formula reduced to 1½ tablespoons. seventy-five cc. transfusion of whole blood, and 75 cc. of 2½% dextrose in half normal saline subcutaneously given. Liver and spleen still 2 cms. and 4 cms. respectively below costal margin in nipple line, and remained about this position throughout the hospital course. Skin, sclerae and mucous membranes all appear intensely jaundiced. Weight 7 pounds, 2 ounces.

Fourth hospital day—R. B. C., 5.15 million; hemoglobin, 18; W. B. C., 9,300; polys., 71 (14 n.f.); lymph., 27; eos., 2; normoblasts, 0; reticulocytes, 4%. Jaundice, spleen and liver size all unchanged clinically. Abdomen more distended, but after being relieved by rectal tube, patient took formula well and passed 3 soft, yellow stools. Eighty cc. fluids given subcutaneously twice. No blood.

Fifth hospital day—R. B. C., 5.90 million; hemoglobin, 17 gms.; W. B. C., 12,000; polys., 68 (10 n.f.); lymph., 29; mono., 2; eos., 1; normoblasts, 0; reticulocytes, 5%. Degree of jaundice and position of liver and spleen unchanged. Continued to take formula fairly well, vomited once. Sixty cc. of subcutaneous fluids given twice. Two soft, yellow stools.

Sixth hospital day—R. B. C., 5.80 million; hemoglobin, 17 gms.; W. B. C., 13,000; polys., 62 (4 n.f.); lymph., 32; mono., 5; eos., 1; normoblasts, 0; reticulocytes, 5%. Appeared less jaundiced, took formula without vomiting. Position of liver and spleen unchanged. More alert. Better coloring. Subcutaneous fluids given twice. Stools well colored.

Seventh hospital day—R. B. C., 4 million; hemoglobin, 15 gms.; W. B. C., 14,600; polys., 58 (6 n.f.); lymph., 39; mono., 3; normoblasts, 0. Patient continued to take formula well with a total of 10 ounces. No parenteral fluids or blood. Took 6 ounces dextrose in saline between feedings.

Eighth hospital day—R. B. C., 5 million; hemoglobin, 14.5 gms.; W. B. C., 17,000; polys., 52 (12 n.f.); lymph., 46; mono., 1; eos., 1; normoblasts, 0. Weight 6 pounds, 15¾ ounces. Sickle-cell study showed no sickling in 48 hours. Hematocrit study—M. P. C., 47 cmm; M. C. V., 94; M. C. H., 29; V. C. H. C., 30; vol. index—1.02. Bleeding and clotting time, normal. Urinalysis essentially negative. Icterus index—133.3 units, van den Bergh, direct +, indirect +++, platelets 250,000/cmm, R. B. C. fragility test,—normal resistance to hemolysis and same as controls red blood cells. Patient began a slow, but steady, improvement from this date on. Took formula well and there was a continuous, but slow, gain in weight. Daily blood counts done until the 13th hospital day and twice weekly after that without significant change in count or smear.

Jaundice diminished slowly clinically and was not discernable by the 20th hospital day. Transfusion of whole blood was given on the 18th hospital day because of an R. B. C. of 3.50 million and hemoglobin of 10 gms. Response to this transfusion was good, with a rise in R. B. C. to 5 million and hemoglobin to 14 gms. Patient discharged on 31st hospital day in good condition, but with spleen and liver still palable below costal margin, and she had just regained her birth weight.

Comment: This case was notable first because of mother's history of increasing infant longevity before demise in preceding 5 infants and mother's decreasing titre of anti-Rh factor antibodies as labor approached. It raised the question of the mother becoming desensitized to the Rh factor, or other hypotheses for this phenomena. Secondly, this infant, like the others according to history, was not jaundiced at birth and also we were never able to find normoblasts. The reason for this is not clear. However, in view of Rh factor determinations and jaundice, we feel justified in placing this case with those usually labelled erythroblastosis fetalis or hemolytic anemia of the newborn. Patient seen in clinic three times since discharge and at 3 months of age has no clinical jaundice. Liver edge palpable at the costal margin. Spleen 4 cms. below costal margin. Blood count shows R. B. C. of 3.69 million and hemoglobin of 10 gms. Weight is up to 11 pounds, 14 ounces, and she is apparently in good health.

Final Diagnosis: Erythroblastosis fetalis.

From Department of Pediatrics, Medical College of the State of South Carolina—M. W. Beach, M. D., Professor of Pediatrics and Clyde D. Conrad, M. D., Teaching Fellow.

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Coronary Occlusion

A Therapeutic Contribution
W. TERTSH LANDER, M. D.
Williamston, S. C.

The frequent careful autopsy reports leave little to desire for a sure diagnosis. In this line only one thing will be presented, and that as a corollary near the end.

In reading these reports we arrive at the conclusion that only one in ten has an actual plugging of the artery. How to manage this ten per cent is thoroughly dealt with in the books, and cannot profitably be discussed here. It is with the 90% we wish to deal. The dangerous ischemia is usually the result of calcium poverty of the blood. If this is corrected, recovery may be expected. Such a case is likely to become chronic, and may need daily supply of calcium indefinitely. Otherwise an acute exacerbation may bring an untimely end. In giving calcium, of course a sufficiency of Viosterol must be included. Several of our best drug houses furnish such a tablet or capsule. There may be habitual call for from two to four a day.

A case in point: W. T. was presented, with classic symptoms of impending death—without pulse or color, and unable to speak. Usual emergency measures were adopted, and conventional care was carried out scrupulously for two weeks. By this time the calcium deficiency was noted. Calcium viosterol wafers were given freely, and graduated exercise was allowed. After six weeks the patient was found in the blacksmith shop seeing about an urgent job. The blacksmith apologized for the absence of his indispensible striker. My impatient patient took the striker's sledge for twenty minutes. No harm came of it. Since then his amusement has been with sledge hammer, grubbing hoe, wood saw, ax—or other cardiac inhibitory—according to whim. BUT HIS CALCIUM HE NEVER OMITS!

A form not recognized by most of us specialy calls for attention. The patient looks right, simply complaining that his strength leaves him and he feels utterly let down. Of course, the electro-cardiograph will settle the question; but the ordinary doctor has no such help. Instead, take the coagulation time. Be sure you take it right. This may be twice the normal or more. Start the calcium and watch the pulse. The change in fifteen minutes may surprise one. Such cases are common. They are incompetent for work, and usually are looked upon as lazy. The laziness is conservative; under hard work they may drop dead. They are safe and may do what they please so long as they keep their calcium sufficient.

Again: The hysteria (?) which often intrudes in any illness will frequently be found to be nerves on the raw for lack of calcium,—an incipient Coronary Occlusion.

The coagulation test is of such fundamental value in these cases that a word here may be worthwhile. The simplicity does not excuse carelessness. It must be done right. Perhaps best for the ordinary doctor is the following method: Take a small Petri dish (or its equivalent from the kitchen). Have in the dish a few drops of water to insure a moist atmosphere. Very carefully clean and dry the underside of the cover. Sterilize the finger scrupulously; dry it before striking with a rather coarse hypodermic needle. Strike deep enough so that little or no squeezing is necessary. Place a large drop on the underside of the cover. Note carefully the time to the second. Tally each 60 seconds. After two minutes, from time to time, test the coagulation, passing a fine pointed pin through the drop. A hypodermic needle does not serve accurately. By this method 150 seconds may be called normal.

What's New

GASTRO-ENTEROLOGY

HUGH SMITH, M. D.
Greenville, S. C.

With only six minutes allotted for this part of the program it has occurred to me that a brief review of a book published in 1943 would be profitable. All of us read, from time to time, something that strikes us individually as really fine.

"Human Gastric Function", Wolf & Wolff, Oxford University Press—1943—is to me a really fine book, a magnificent contribution to medical literature. An understanding and appreciation of physiology is admittedly basic in the study of pathology. Our interest in and appreciation of emotional influences has broadened our clinical usefulness. Psychosomatic disease is indeed an important part of our days work as clinicians.

"Human Gastric Function" is a report of a long experimental study of a man and his stomach by Stewart Wolf, Capt. M. C., A. U. S. and Harold G. Wolff, M. D., Associate of Medicine, Cornell University Medical College. In the introduction the authors review briefly the important contributions of Beaumont in 1833 in his studies of Alexis St. Martin. Beaumont's interest was largely with the gastric juice and its influence on the ingested foods. Richet, who in 1878 studied an early gastrostomy patient, was mainly interested in the chemical and physiological properties of gastric juice. Carlson, in 1912, with a similar patient, was primarily interested in kinetics and the majority of his experiments concerned motility and hunger contractions. Pavlov, in 1910, had shown the effects of environmental influence on gastric function of experimental dogs. Connor, who probably has exerted the greatest influence on clinical medicine of any physiologist, in 1909 published some of his works on 'The influence of emotional states on the functions of the alimentary canal.'

The significance of psychosomatic relationships looms large in clinical problems today. It is from this vantage point that Wolf and Wolff have made such a brilliant contribution.

The subject of his work, Tom, was 57 years old, of Irish stock and a person with some insight and of an independent nature, subject to the same emotional and physical influences of an average working man with a family. At the age of 9 Tom drank some extremely hot clam chowder and as a result an oesophageal stricture, resistant to dilatation, occurred. Gastrostomy was necessary and from that age on Tom fed himself through the operative stoma. He learned quite early that by chewing his food before funnelling it into his stomach that he could maintain good digestive health. As a boy he was active in school games and as an Irishman not averse to a fight. He smoked a pipe moderately and drank a few beers, of which he would swallow a small amount to be regurgitated before pouring the rest directly through his funnel. He did not use much whiskey because small amounts spilled around the stoma irritated the granulating tissue surrounding it. He learned that it took about five hours for a meal to be digested and clear his stomach, and noted that liquids were generally digested quicker than solids. He found that meats required 6-9 hours and that leafy vegetables remained in his stomach for 10-12 hours. He fed himself twice a day and found it wise to wait 6 or more hours between feedings to prevent the reflux of stomach contents on uncovering the stoma to feed again.

In this case there was a defect midway between the xiphoid and umbilicus, 3.5 cm in diameter, through which herniated a collar of gastric mucosa about 10 cm across. It was possible to replace all of this tissue through the opening and to maintain it in place by a pressure gause bandage between feedings and studies. It is remarkable indeed that Tom was free, generally, of all so-called chronic indigestion. He had no evidence of chronic gastritis and no ulcerations. The stoma was large enough to allow the introduction of a lighted *scope* for direct visualization and even for photography. Specimens could be withdrawn at will so it is evident here indeed was an ideal situation to study Human Gastric Function and the authors were splendidly equipped in every way to do so.

Each chapter details an experimental study and the conclusions derived therefrom. Of course, as the authors point out, these studies were done on one human stomach. But the fact that this man had lived a fairly normal life since age 9 with his gastrostomy, and that he was a rather normal individual with the usual ups and downs, make it reasonable to believe that the conclusions drawn are, to all practical purpose, generally accurate.

This book reports a monumental contribution and I recommend it to you as something fine that you will thoroughly enjoy.

SIGNIFICANT RECENT ADVANCES IN OBSTETRICS

J. DECHERD GUESS, M. D.
Greenville, S. C.

The most significant of the several recent advances in obstetrics consists in a greatly improved realization of the importance of proper nutrition during pregnancy. Not only has there occurred more wide spread and more profound realization of the ill effects of improper nutrition, but there is equally wide spread and more profound acceptance that proper nutrition has numerous and significant good effects. Along with this has come a better understanding of the component elements of diet designed to furnish adequate nutrition and a clearer understanding of why these diets furnish the adequate nutrition they do.

A pregnant woman expends more work-energy than does a non-pregnant woman. Consequently her caloric requirements are definitely greater, (about 20 per cent in the second half of pregnancy) than they were before pregnancy. The non-pregnant woman requires about 2200 calories, while the gravida should have 2500. However, to supply these caloric requirements alone is not sufficient. There are specific and peculiar requirements regarding the kind of food. Her own personal requirements include an increased protein intake to furnish and to replenish energy and to equalize her protein metabolic ratio.

She also requires protein with which to build her baby's body. The daily protein requirements in the second half of pregnancy is 85-100 grams as compared with 60 gm. in the nongravid woman.

On the other hand her carbohydrate and fat requirements are not only not higher but are actually lower than before pregnancy, and excess intake during pregnancy results in stored fats within her own body and that of her baby with weight increase and consequent unnecessarily increased burden upon her circulatory system, her excretory system and her skeletal system.

There is an increased need of vitamins and minerals to meet the requirements of her and her baby.

Therefore the present concept is that a pregnant woman requires a diet high in proteins, rather low in carbohydrates and quite low in fats, but rich in minerals, especially calcium and iron, and very rich in vitamins—all of them.

There is much published and unpublished experimental work on diet in pregnancy. Within the next year or so there will be probably much more. Dr. Lull and his group in Philadelphia began their studies before the war, they were interrupted by the war and have just recently been resumed. This group has some very definite ideas, with supporting figures, regarding the benefits of a good diet in pregnancy. Dr. Lull believes that it has reduced almost to nil their toxemias of late pregnancy, has eradicated their symptoms of circulatory, muscular and emotional exhaustion, that it has made for longer, stronger babies, of more adequate weight, that it has greatly reduced the incidence of premature labors, and that it has hastened convalesence after delivery.

The Harvard group has found that a similar diet has similar beneficial effects. An exhibit describing a good diet in pregnancy has been arranged by Dr. Hilla Sheriff of the M. C. H. Division of the State Board of Health and her co-workers and you will find it interesting and instructive. As a part of a diet such as this there should be included one or more capsules of therapeutic, (in distinction from prophylactic) multi-vitamins. A good capsule of this type is Upjohns Zymacaps.

Perhaps, the next most significant recent advance in obstetrical knowledge has to do with the maternal and infantile effects of heterology in father and mother with regard to the Rh factor and certain other more rare blood factors. Because of this knowledge, it is now just as important to test for the Rh factor as it is to test for syphilis in early pregnancy. Rh negative women should not receive blood from Rh positive donors, nor should they mate with Rh positive men, and if they do they should avoid parenthood. The pediatrician should make special preparations to receive a child from such a mating. It is strongly likely to have congenital jaundice or massive edema, it may be stilborn or die shortly after birth, and the incidence of deformities is very high.

The last advance that can be mentioned in this short discussion and that only briefly is the increased availability of specific chemotherapy for treatment and prevention of puerperal sepsis. Penicillin is easily available and is relatively inexpensive. Penicillin in oil and wax makes office and home treatments practical. Sulfadiazin has relatively fewer side effects and is usually much better tolerated than were the earlier sulfa drugs. These agents have proven almost as dramatic in the treatment of post-abortional and post-partum infections as they have in the treatment of pneumonia. Streptomycin has just become available. It promises to be highly useful in a small group of infections of pregnancy and the puerperium not responsive to sulfanamides or penicillin. B. proteus urinary tract infections are important examples.

The Journal of the South Carolina Medical Association

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JANUARY, 1948

JAMES McLEOD

In the passing of James McLeod, South Carolina lost one of her leading citizens, our Association lost one of her most aggressive leaders, and his colleagues lost one of their most valued and loyal friends. His sudden death came as a great shock to those who knew him and expressions of sympathy and of appreciation for his life and work poured in from every section of the state.

Of the many tributes which were written we have selected the one which we believe would have appealed most to him were he living, since it appeared as an editorial in his home-town paper, the Florence Morning News. It expresses the sentiments and feelings of those who knew him best and loved him most, the people of his own community.

"This community has been deeply shocked and grieved by the sudden death of Dr. James McLeod. He was so much a part of Florence and had rendered such a conspicious service to this entire section of South Carolina that his passing leaves a very great void which will be exceedingly difficult to fill.

"Dr. McLeod's chief claim to recognition was as a physician and surgeon. He was the son of a father of equal distinction who founded Florence's McLeod Infirmary and developed it into one of the leading such institutions in the South. Dr. James, as he was commonly called, had himself been active superintendent and chief surgeon since 1935. In this capacity he had carried on in a manner satisfactory to all the great work of his father. Moreover, he had earned wide recognition in his profession, being named to membership in numerous national medical societies and elected president of the South Carolina Medical Association.

"Two years ago when a back ailment made it clear that he would have to discontinue surgery, Dr. McLeod caught a vision of serving his state. He was like that. If the door to service closed in one area, he would turn to another. And in whatever direction he spent his energies, he did so with complete abandon. Entering the race for governor, he threw himself into the campaign with all of his mental and physical powers. The result was a magnificent campaign in which he polled great support throughout the state, and as a result of which he firmly planted himself in the state's political picture. One of two things was certain. He would either bide his time and offer for governor at the next election, or he would throw himself into the race for United States Senate. Certain also was that whichever race he entered, he would have an excellent chance of victory.

"Dr. McLeod was no self-seeking politician. Those who knew him best knew that he aspired to serve his state and his nation as a statesman would. In the governor's mansion or the United States Senate, he would have rendered an able and fearless service to his people. That death intervened and prevented the realization of these aspirations is the state's and the nation's loss.

"It is doubtless true that the heavy responsibility he had carried as superintendent of the hospital, as citizen of Florence, and as one who aspired to serve his state and nation contributed to the heart attack which proved fatal Tuesday. The utter abandon with which he sought to attend to the best interests of all these many activities could not but produce a severe strain on his physical constitution.

"No word, however, would be complete without reference to his worth as a citizen and as a personal friend. He had led in so many worthy civic undertakings that much of Florence's life was identified with him. His human qualities were so genuine that many have said since his death, 'He was the best friend I had'.

"He will be missed in South Carolina. But South Carolina has reason to be grateful that he and his distinguished father were listed among her citizens. For they wrought a good work, and the influence of it will remain."

OUR NEW FRONT COVER

Since this is the Centennial Year of our Association it was thought wise to prepare a front cover which would not only be more attractive to the eye but would also be in keeping with the celebration of a one hundredth birthday. We hope that the efforts of the artist, based upon general suggestions which we made, will appeal to the members of the Association.

MEDICAL COLLEGE EXPANSION

In building a home, a man goes through three definite procedures. First he makes or has made a sketch of the proposed house, being sure that it will meet his needs, then he makes the necessary financial arrangements to care for the cost, and finally he supervises or contracts for the supervision of the actual building itself. These are logical steps for him to take and one would be thought a fool who did not adopt such a course of action.

When the Medical College found itself in need of expansion it adopted these same procedures which the head of family would use. First, the Dean and his special Advisory Committee made a detailed study of the situation and evolved a blue-print for action. This was presented to the Board of Trustees, and approved. A study by an out-of-state consultant showed the need for the program as outlined. The blue-print was next submitted to the South Carolina Medical Association which also approved the plan, following careful study by a special committee of seventeen.

The first step complete, the next objective was the securing of necessary financial support. A bill was introduced into the General Assembly calling for an appropriation from the state treasury to take care of the expense. The 1946 request was for $1,500,000. In 1947 this request was raised to $3,500,000 when it developed that the federal government would bear only one third and not two thirds of the cost, as had been anticipated. The bill was enacted into law last spring and recently was signed by Governor Thurmond. The second step was complete.

Just how soon the third procedure, that of actual building, will begin will depend upon the Board of Trustees but we feel sure that it will not be in the distant future.

As this Expansion Program has gradually developed, many have played a role. Physicians, legislators, and friends of the Medical School have all done their part. But as in any movement, there have been certain leaders and to these must go the most credit. Dean Kenneth Lynch who spearheaded the original study, and who worked so strenuously with the legislators to have the final bill approved. The Advisory Committee to the Dean who helped prepare the blue-print for expansion. Dr. T. A. Pitts, Chairman of the Board of Trustees who worked so closely with Dean Lynch. The Board of Trustees of the Medical College. The Committee of Seventeen of the S. C. Medical Association who made a careful study of the program as presented and who did so much to acquaint the members of the Association and the public with the true facts in the case. The late Dr. James McLeod, Chairman of the Committee of Seventeen, who, practically single-handed, was responsible for the passage of the original bill in 1946. To these, and to others whose names we do not have space to record, the medical profession of South Carolina owes a debt of gratitude. And not only the profession of today but the physicians of tomorrow who will reap the benefits of the enlarged Medical College as they pursue their courses of study. The public itself also owes these men much, for it is primarily for the benefit of the public that the Expansion Program has been put into action. With increased facilities, the college can not only retain its high rating but can improve its work—and in the ultimate, it is the average citizen in the state who will profit most from this.

COMMITTEE FOR YOUTH

At an open meeting of the Committee for Youth of South Carolina there were about a hundred people present. The speakers were introduced by Mrs. Kate B. Helms, who acted as chairman. The speakers were Dr. George D. Johnson, who represented the medical profession; Rev. Maxie Collins from Columbia, Assistant Director of South Carolina Federated Forces; Mrs. Eugene Spearman of Newberry, Executive Secretary of the South Carolina Division of the Southern Regional Council; Miss Lucia Murchison, Medical Social Work Consultant, Division of Maternal and Child Health, South Carolina Department of Health.

The idea behind this committee for the youth of South Carolina is to get information in each county about everything pertaining to youth. For example; from a doctor's standpoint, information such as how much money is spent for public health, how many patients are treated for syphillis, for tuberculosis, how many injections against communicable diseases are given, how many visiting nurse visits are made, and all the information pertaining to the health would come under this.

In other fields, how many days or weeks are spent in the school, how much is spent for the education of white and colored, how much home economics is taught and everything pertaining to the proper education of children. In other words, in every county, there will be set up a committee composed of a representative from each of the main divisions which make up the South Carolina Committee for Youth.

What we are going to do with this information remains to be seen, but the mere collecting of it will

help inform the people about their county. For example, there is a book gotten out by the Russell Sage Foundation whose title is, "Your Community". This book has all the questions which should be asked about any different department. For example, it has in there questions which we should know about our medical department, how much is spent per person, how it's spent, how much is spent for inspection, and all that type thing. These are the questions which this committee should investigate, and when we get all the answers we will have a wealth of material. Then we can draw our conclusions and perhaps help influence our legislature to create laws which would correct some of the more glaring mistakes. That is the purpose behind this committee. I think it is a very worthwhile thing, and I think it would be foolish for doctors not to participate. Doctors, as a rule, are in the doghouse because of their reluctance to take part in community affairs; and I think this is one opportunity where we can really step out and express ourselves on the health of our community. What we as doctors think should be corrected when we as doctors recommend. That is the purpose of this meeting.

Geo. D. Johnson

Special Meeting House of Delegates

Nov. 22, 1947 — Columbia, S. C.

The meeting was called to order by the President, Dr. Olin Chamberlain at 2:40 p.m. There were forty delegates present.

Dr. Chamberlain relinquished his chair to Dr. C. H. Blake, Vice President, while he, as Chairman of the Special Committee of Eighteen, presented his report.

Dr. Chamberlain outlined the method of creation of the special committee and told of its activities. He stated that the committee had secured the services of Dr. Harry Mustard of New York City, to make a special survey of the South Carolina State Board of Health during the month of August. Subsequently, the committee conferred with Governor Strom Thurmond and secured his ideas on the subject. Upon the basis of Dr. Mustard's report, Governor Thurmond's suggestions and its own study, the committee prepared its own report which Dr. Chamberlain then presented, giving each delegate a mimeographed copy (printed in full below).

Upon the recommendation of the secretary the members of the Committee of Eighteen who were present were allowed the privilege of the floor without the power to vote.

A resolution was presented by Dr. N. B. Heyward which was passed unanimously, thanking the committee for its work.

A motion was made by Dr. N. B. Heyward calling for a recommendation to the General Assembly that the State Board of Health in South Carolina as now constituted be left in statu quo. This motion was tabled with a vote of 29 to 6.

Motion made by Dr. Blake instructing the Executive Secretary to send a copy of Dr. Mustard's report to each member of the House of Delegates for study and that a subsequent meeting of the House of Delegates be held to consider the entire matter, was tabled 18 to 12.

Dr. J. D. Guess then introduced a resolution calling for an adoption of the report of the Committee of Eighteen and with instructions to the President of the Association to do all within his power to have the necessary legislation introduced into the Assembly and to secure its enactment into law. This resolution was adopted by a vote of 34 to 4.

An amendment to the above resolution calling for the addition of a pharmacist to the membership of the State Board of Health as outlined in the report was tabled by a vote of 26 to 8.

There was full and free discussion during the two hours of the session with the following individuals participating: Drs. A. B. Preacher, N. B. Heyward, Robert Wilson, Adams Hayne, George D. Johnson, William Weston, Robert Durham, Hugh Smith, Wyman King, James Snyder, J. D. Guess, J. R. Kirkpatrick, J. K. Walsh, W. R. Wallace, J. H. Stokes, C. H. Blake, Frank Cain, Mr. M. L. Meadors, Drs. A. W. Browing, J. W. Chapman, I. H. Grimball, A. J. Josey, T. G. Goldsmith, J. P. Young, E. M. Dibble and J. P. Price.

REPORT AND RECOMMENDATIONS OF COMMITTEE OF 18

Paragraph 1: That the powers and duties now vested in the State Board of Health and in the Executive Committee of the State Board of Health be transferred to and vested in a State Board of Health of nine members to be appointed by the Governor as hereinafter set forth.

Paragraph 2: That the Governor shall appoint a State Board of Health made up of nine members, including five physicians, one dentist, and three other citizens of the state none of which three shall be a physician or dentist; that members of the Board shall be appointed in the categories set forth above as provided respectively in paragraphs 3, 4 and 5; that one physician be appointed for a term of one year, that one physician be appointed for a term of two years,

that one physician and one non-physician be appointed for a term of three years, that one physician and one non-physician be appointed for a term of four years, that one physician and one non-physician be appointed for a term of five years, and that one dentist be appointed for a term of five years, all such appointments to date from the first Friday in July 1948; that appointments subsequent to that date, except for the filling of unexpired terms, shall be for a period of five years and until a successor is appointed and qualified, and shall be made from the same categories respectively and in the same manner as those of the original appointees as above provided; that except members who have not served for as long as twenty-four months, no member may be appointed immediately to succeed himself or herself but may again be appointed a member of the Board after one year absence from such membership; that when a vacancy occurs, other than through expiration of term of appointment, the person appointed shall be qualified within the category in which the vacancy occurs and his or her term of office shall be the unexpired term of office of the person whom he or she shall succeed; and if this unexpired term shall be twenty-four months or more, the member who fills it shall be considered as having served the equivalent of a full term insofar as concerns eligibility for future appointment. Members of the State Board of Health shall be removable by and at the pleasure of the Governor for neglect of duty and other causes after a hearing by the Board, when at least five members of the Board certify to the Governor in writing that such a hearing has been held, and that they believe the charge or charges which they shall set forth, have been sustained and are sufficient cause for removal; provided: that no member shall be removed from the State Board of Health unless thirty days before the hearing of charges, he or she shall have been advised, in writing, of the specific charge or charges, against him or her and of the time and place for such hearing.

Paragraph 3: That Section 4997 of the Code of 1942, and such other sections as may be concerned, be so amended as to provide that the South Carolina Medical Association, at its first meeting after January first, 1948, shall elect nine members, to be recommended to the Governor on or before the next ensuing first Friday in June and the Governor shall appoint five of them, with others as set forth in paragraphs 2, 4 and 5, hereof, to constitute a State Board of Health, and that the Governor shall designate the term for which each of the five shall be appointed, as provided in paragraph 2 above; that at each annual meeting subsequent to the first one after the first of January, 1948, the South Carolina Medical Association and their successors, in their corporate capacity, shall elect three members, to be recommended to the Governor, on or before the next ensuing first Friday in June of each succeeding year, and the Governor shall appoint one of them to serve as a member of the State Board of Health for a period of five years.

Paragraph 4: That Section 5222 of the Code of 1942, and such other sections as may be concerned, be so amended as to provide that the South Carolina Dental Association, at its first meeting after January first, 1948, shall elect three members to be recommended to the Governor on or before the next ensuing first Friday in June and the Governor shall appoint one of them, with others as set forth in paragraphs 2, 3 and 5, to constitute a State Board of Health; and that at each fifth annual meeting subsequent to the first one after the first of January, 1948, the South Carolina Dental Association and their successors, in their corporate capacity, shall elect three members, to be recommended to the Governor, on or before the next ensuing first Friday of June, and the Governor shall appoint one of them to serve as a member of the State Board of Health for a period of five years.

Paragraph 5: That on or before the first Friday in July, 1948, the Governor shall appoint three citizens of the State, none of whom shall be a physician or dentist and who, with others as set forth in paragraphs 2, 3 and 4, shall constitute a State Board of Health, and that the Governor shall designate one of such citizens as appointed for a term of three years, as provided in paragraph 2; one for a term of four years, and one for a term of five years; that on or before the first Friday in July, 1951, the Governor shall appoint one such citizen, who shall not be a physician or dentist, to succeed the member originally appointed under this paragraph for a term of three years; that on or before the first Friday in July, 1952, the Governor shall appoint one such citizen to succeed the member originally appointed under this paragraph for a term of four years; that on or before the first Friday in July, 1953, the Governor shall appoint one such citizen to succeed the member originally appointed under this paragraph for a term of five years; that on or before the first Friday in July of each of the last three years in each succeeding five year period thereafter, dating from July, 1953, the Governor shall appoint one citizen of the state, who shall not be a physician or dentist, for a term of five years, to fill the term of the member in this category expiring in each of such years; and that when vacancies occur in this category of the membership of the State Board of Health, other than through expiration of term of appointment, the Governor shall, within his discretion, and in not less than thirty days, appoint a citizen of the State, who shall not be a physician or dentist, to fill the vacancy.

Paragraph 6: That if the said South Carolina Medical Association, or the South Carolina Dental Association, fail or refuse to make recommendation to the Governor as set forth respectively in paragraphs 3 and 4, then the Governor shall, within his discretion, appoint physician members of the Board, or dental member, as may be necessary.

Paragraph 7: That the State Board of Health, as provided for above, shall meet on the first Friday in July, 1948, shall proceed to organize and elect a chair-

man and secretary and is hereby empowered to adopt by-laws for the conduct of its business and to amend such by-laws. The Board shall meet once in each month and at other times when called by the Chairman or at the request of four members of the Board. It shall fully and completely record its actions and shall carefully preserve its records, and the State Health Officer is hereby authorized, within the limits of his budget, to utilize the services of such persons as are already employed by the State Board of Health as now constituted, to assist the Board in recording its actions and otherwise to assist the Board in the conduct of its business. The Board shall render an annual report to the Governor and the General Assembly. Members of the Board shall be entitled to compensation and to reimbursement of expenses as now provided.

Paragraph 8: That it shall be the duty of the State Health Officer, appointed and holding office as now provided by law, to perform the duties and functions required of him under the existing laws of the State of South Carolina and to administer the activities of the State Board of Health as constituted under the terms of this Act and under the direction of the said State Board of Health, to whom the State Health Officer shall be at all times responsible, and it shall be the duty of the State Health Officer to see that all acts relating to the public health are enforced, subject to the direction and authority of the State Board of Health as herein constituted. He shall be responsible for enforcement of public health laws enacted in the future and for the enforcement of all regulations of the State Board of Health now existing or which the Board may in the future promulgate. He shall submit an annual report to the State Board of Health and the said Board shall transmit the same to the Governor along with, or incorporated as a part of, the annual report of said State Board of Health.

THE TEN POINT PROGRAM

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

THE STATE MOVES FORWARD

South Carolina is making progress in her efforts to deal with problems related to medical care. There is ample evidence of the fact, after a long period of lethargy in which the law-makers, doctors, and the public alike seemed entirely content with the conditions which had existed for many years. The General Assembly has taken definite steps toward expanding and increasing facilities which will mean real contributions toward the improvement of medical care in the State, and toward widening the base on which it shall be made available.

With the signing by Governor Thurmond of the Bill passed by the Legislature at its last session, providing for distribution of the ten million dollar surplus in the State Treasury, the development of the program of the Medical College of South Carolina is assured. Last year also, the Legislature passed an Act which became law promptly, providing the machinery to be used by the State in obtaining, and in the administration of the funds made available by Congress under the Hill-Burton Act.

It is gratifying to recall that in both these matters the South Carolina Medical Association had an active part. The original appropriation of approximately one and a half million dollars, the amount then considered as necessary for the expansion of the Medical College, was put through the Legislature largely as the result of the work of the Committee of Seventeen, of which Dr. James McLeod was the resourceful and energetic chairman. All of the influence of the Association was brought to bear with the result that the Bill was passed at the same session of the Legislature in which the activities of the Committee of Seventeen had been exerted.

The set-up of the division of the State Board of Health which will administer South Carolina's participation in the hospital expansion program under the terms of the Hill-Burton Act, was the result of thought and effort on the part of a joint committee from the Association, the State Hospital Association and the State Board of Health. Except for the fact that the plan proposed by this joint committee would have provided for a separate commission, whereas the Legislature provided for a separate division within the State Board of Health, the Legislature adopted the plan proposed with only minor changes.

This year, following its agreement with the leadership of the Medical Affairs Committee of the Senate, the Association has made a study of the Board of Health and has submitted definite recommendations with respect thereto. These recommendations, approved and adopted by the House of Delegates, are proof, if proof were needed, of the ability and the desire of the medical profession in South Carolina to cooperate with the law-makers and others outside of the profession in the general interest of the public.

Finally, the Association undertook during the last session to do something about the cults and unrecognized practitioners in the State. A determined effort was made to bring about an investigation of the practices of the Naturopaths and their Board of Examiners. For the benefit of the public, that effort should and will be renewed with determination in January. These are the sort of activities which the

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
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Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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public has a right to expect from an organization as influential, as strong, as equipped for leadership in the affairs of the State as is the South Carolina Medical Association. It is through such efforts that the medical profession here and elsewhere can best convince the public of its genuine intentions in their behalf, and thereby postpone the evil day of medical care by government fiat.

NEW PUBLICATIONS

The month of November saw the addition of two new features in the publications released from the central offices of the Association.

On November 1st, or near that date, the first South Carolina Medical Association News Letter was mailed to all members of the Association. The second was published shortly after the first of December. It is hoped, through this medium, to supply the members of the Association throughout the State with bits of information of interest to them and related to the profession and its welfare, particularly in South Carolina, more rapidly than can be done through the pages of the Journal. Because of the circumstances under which the Journal must be prepared and printed, it is impossible to include in its columns information regarding current activities as quickly as might be desirable. It is hoped that through the News Letter, the members can be kept currently informed while the news is fresh, and the medium should serve as an excellent supplement to the services already available through the Journal.

The second feature added within the past month was the change in the content and concept of the Bulletin, which, with the issue last month, completed its first year. With the November number the name was changed from "Bulletin" to "Auxiliary Bulletin", and became the joint enterprise of the Association and the Woman's Auxiliary.

The Association and the Auxiliary are indebted to the late Dr. James McLeod for his vision and inspiration in instituting the Bulletin. It is published quarterly in mimeographed form from the Executive Offices of the Association in Florence, the first number having appeared in February 1947. The first three numbers were devoted to discussion of matters of interest to the profession, particularly along political and economic lines, with especial emphasis on the Wagner-Murray-Dingell Bills and the Blue Cross Plan. The original idea was, through this means, to reach the members of the Auxiliary with accurate and direct information which would enable them to participate actively in the public relations program of the Association. It is believed that the members of the Auxiliary, through their contacts and with the time at their disposal, are in better position to work effectively in connection with many of these projects than are the members of the Association themselves.

Some time ago it was suggested to the President of the Auxiliary that the officers might wish to use the columns of the Bulletin as a medium for the release of information to their members. The suggestion was immediately approved by Mrs. Adcock, the President, and her Executive Committee. She cooperated in the venture from the beginning and most of the material contained in the November issue was supplied by Mrs. Adcock and other officers of the Auxiliary.

The ladies in many of the states have their individual publications. It may be that in South Carolina eventually they will wish to do the same. For the time being, the Bulletin in its present form however, can serve in the dual capacity of an organ for the Woman's Auxiliary and a means of informing its members, through the facilities of the offices of the Association, on current developments of interest to the medical profession.

BARUCH PROPOSES PLAN TO IMPROVE NATION'S HEALTH

The stature of Bernard M. Baruch is such that his public utterances on any subject awaken genuine interest on the part of the public and are attended with respect. That is generally true in South Carolina to an even greater extent than elsewhere. Despite his long residence in New York City and his position as a world figure, South Carolina still regards Mr. Baruch as, in a sense, peculiarly her own. He has kept his contact with the State in many ways, being a part-time resident at his beautiful home, Hobcaw Barony, on Winyah Bay across from Georgetown.

And when Mr. Baruch speaks of medicine, the problems of the profession, and the steps that should be taken to improve the nation's health, there is every reason why the medical profession of South Carolina should turn an ear and note what he has to say. His father was once President of the South Carolina Medical Association. The auditorium at the Medical College of South Carolina bears his name and is as the result of his generosity.

On November 19th, Mr. Baruch addressed approximately 600 physicians and hospital administrators at a dinner in New York, and according to New York Medicine, a publication of the Medical Society of the County of New York, "called on the medical profession to assume leadership in providing better health for the people of America".

There is a somewhat familiar ring about the expression used in referring to the address, in stating that it outlined a program "for improving medical and hospital services with provisions for government-financed protection for needy individuals". A good many of the points suggested in Mr. Baruch's address apparently were things that had been proposed in other quarters, and which perhaps may have been discussed from time to time. Their further projection

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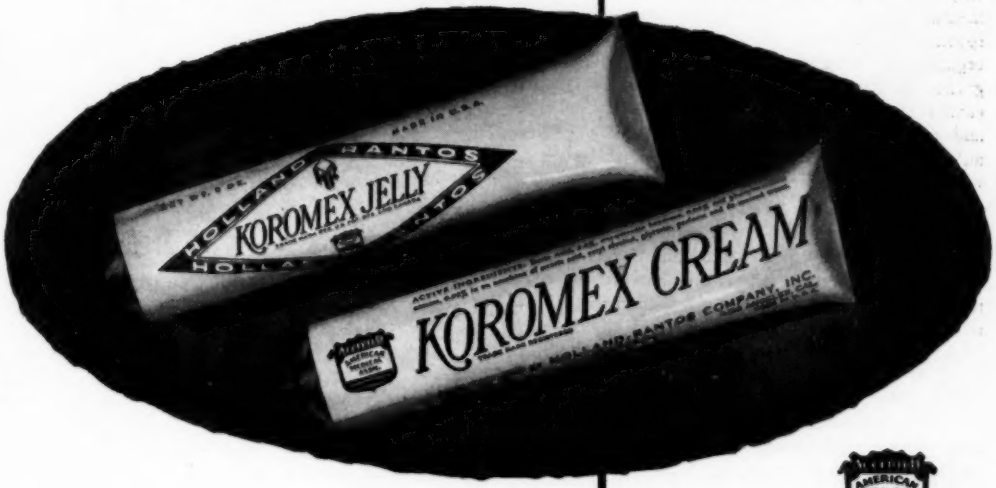

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by Mr. Baruch, a man of keenly analytical mind and excellent judgment, tends to entitle the subjects to further consideration by the profession and the thinking public. The article in New York Medicine continues:

"Pointing out that many doctors have been fighting a 'rear guard action' in providing medical care for all classes of the people, Mr. Baruch urged that the medical profession accede to the public demand for more and better medical services. He also stressed the need for cooperation with the government in obtaining government aid where necessary.

"Among the steps he specifically advocated were a survey to modernize medical education with greater emphasis on chronic and degenerative diseases, mental hygiene, and preventive medicine; fewer specialists and more general practitioners; the reorganization of medical practice with emphasis on group medicine and voluntary insurance; a new cabinet post for health, education, and social security; and the creation of a non-political watchdog committee to safeguard progress in medical care for veterans.

"Referring to the need for government aid in raising medical educational standards, Mr. Baruch said: 'If science and medicine ask the Government for aid, which even the conservative deems necessary, they must expect he who pays the fiddler will call the tune. This means the government will rightly insist on no discrimination in medical care because of race, color, or creed. It will rightly insist upon opportunity for all to enter the profession and advance on the sole basis of ability and character, without restrictions of race, color, creed, or sex. And, I hope, without fear of, or favor from, the State'.

"Mr. Baruch congratulated the physicians on their part in proving voluntary health insurance to be 'a sound practical way' of financing health services. Although, he said, they might in time serve the needs of the bulk of the people, he nevertheless voiced concern for 'that sizeable segment of society which does not earn enough to pay for voluntary insurance'.

"To provide for this group he recommended a program partially financed by the government, to be administered by a body of doctors and non-doctors to keep medical care as free from politics as possible. He suggested a form of health insurance with adequate safeguards for those who cannot pay for voluntary insurance. This can be achieved, he said, without involving 'what has been termed socialized medicine'."

Despite the fact that, as reported above, Mr. Baruch's program would provide for partial financing by government, it is indeed reassuring to the members of the profession to note his further remark in this connection. Mr. Baruch believes, according to the report of his ardress that

"The needs can be met, as in other fields, without the government taking over medicine, something I would fiercely oppose."

CULTIVATING RELATIONS WITH THE PUBLIC

It is always pleasing to note that some figure whose expressions are apt to be listened to with a bit more interest than our own, expresses the same thoughts that one has already expressed perhaps in different vein, not once but over and over again.

Dr. George F. Lull, Secretary and General Manager of the American Medical Association, made some comments on public relations in speaking to a luncheon audience at the 18th Annual Scientific Assembly, sponsored by several organizations interested in medicine and medical care in the District of Columbia. According to Dr. Lull, as reported in the November issue of the Medical Annals of the District of Columbia, "The best public relations consists of 80 per cent doing and 20 per cent publicity". The writer in the Annals, himself no mean authority on the subject, continues: "After all, the only purpose of a public relations program is to create good will and understanding. To attain this goal, the medical profession must earn it.

"There is no substitute for good medical care provided by competent and considerate physicians. This, of itself, will do more than anything else to instill confidence and create good will. Radio programs, speakers' bureaus and daily health articles are certainly worthwhile as health educational projects, and reflect credit on the profession. Equally important is the development of plans which will relieve the patient who is heavily burdened by costs of illness. There are, of course, many other ways of winning public support, but these are a few of the tangible evidences of the sincere interest in public welfare which deserve and receive public commendation."

AMERICA IN MEDICAL PROGRESS

Speaking before the 100th meeting of the Medical Society of Virginia in October of this year, Richard H. Shryock, Ph. D., Professor of History at the University of Pennsylvania, traced interestingly the progress of medicine during the past century, the changes in theories and principles on the treatment of disease, and the ever increasing part which research has played in the development of the science of medicine. He pointed out some of the reasons for the delay in many of the discoveries and their slow improvement, which, in the past few decades, have almost revolutionized some types of treatment. He showed that circumstances, economic and political, have had important bearing upon the development of medical research and practice.

Perhaps the most interesting and important of all the observations of Dr. Shryock, are those with respect to the part played by America in this development, and particularly the position which she now

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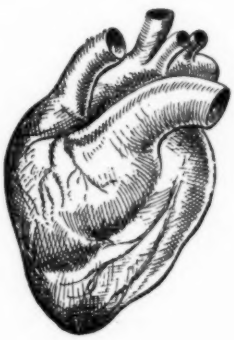

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occupies. His paper, reported in full in the December issue of the Virginia Medical Monthly, pointed out how medical bacteriology led to antiseptic surgery, to a science of immunology, and eventually to an effective chemotherapy, also how it advanced disease identification and diagnosis to a most effective level. When it was possible to add to the criteria of symptoms and of lesions, the knowledge of the cause of these evidences of disease, rapid development of methods of treatment was a matter of course.

"When did American medicine join in this triumphant scientific procession?", the writer inquires. "Until about 1890 it largely followed in the rear, taking over its science from France until about 1860, and from Germany thereafter. Basically, as noted, the lag in American research can be ascribed to the fact that we were a practically-minded people concerned largely with the end-results of research. This was not because the United States was a 'new country', or because it lacked either the population or wealth to advance medical science had its people so desired. During the War Between the States, military surgeons amassed the greatest collection of pathologic data available anywhere in the world but did relatively little with it. Prestige in the American medical profession lay in successful practice, since this seemed practical and also led to income that accorded social standing. Research that had no bearing on cures, on the other hand, seemed impractical, brought no wealth, and so was tolerated rather than supported by either government or private philanthropists.

"In my opinion, the American people have not changed in this regard: we still seek that which is practical and we still cultivate efficiency. Do not let us under-estimate these attitudes, by the way, for there is much to be said for them. The very Europeans or Latin-Americans who ridicule our so-called 'materialism' are quite glad to take over our practical technology, or to seek the financial aid which is made possible only by our combination of commercialism and generosity. But the fact remains that our national attitudes did not encourage the support of pure research before 1890. How, then, explain the sudden appearance of first-class medical science in this country after that time?

"If Americans did not change, two other factors did. First, the discoveries of Pasteur's day revealed for the first time a type of basic research that *did* lead almost immediately to practical results. Immunizing vaccines and serum therapy were very practical and Americans sought them avidly. Pasteur's work was barely under way before such Americans as Sternberg were making similar studies, within a few years certain of our fellow-countrymen were abreast or even ahead of European contemporaries. This can be seen in Theobald Smith's pioneer discovery of the insect vectors of certain infections. After 1900, American sanitary engineering—based now on bacteriology as well as on mathematics—became as good or better than that of any other land. And we all know of the amazing progress of our native surgery during the Mayo era. Today, even the most basic cancer studies seem to be based here on the conviction that, after all, such research will really prove the quickest way to secure useful results.

"One other factor changed in this country, which also aided in placing American medical science in the van of world progress after 1914. This was simply the accumulation of great wealth, based on natural resources and on a superior technology. While some wealth was always necessary to support science, all the medical progress that has been noted rapidly made medical research—as well as medical practice—far more expensive than it had ever been before. The pathologist of 1850 needed as equipment only a table, washstand, a few chemicals and a surgical kit; while the clinician called only for some drugs, a lancet, and a stethoscope. Compare this with the elaborate and expensive equipment now required in medical laboratories or even in the wards. It was what the old astrologers would have called an 'angelic conjunction', that just when medical science became ever more costly, American institutions became ever more wealthy."

Then follow the most important observations, with which Dr. Shryock concludes his paper.

"Of course, medical faculties always feel that their schools are short of funds; but compare their situation with that of many European institutions. The recent war has made this contrast more glaring. Next year, the medical school of Padua—one of the historic seats of early medical progress—will have just fifteen dollars available for the purchase or repair of microscopes. Ten or twenty students must use the same instrument.

"Relatively, then, American medical science stands today in a position of unique advantage. It is our task, perhaps more than that of any other single nation, to carry the torch of medical discovery which has been handed on by great European predecessors. The realization of this situation should lead, not to national complacency, but to a determination to be worthy of this grave responsibility."

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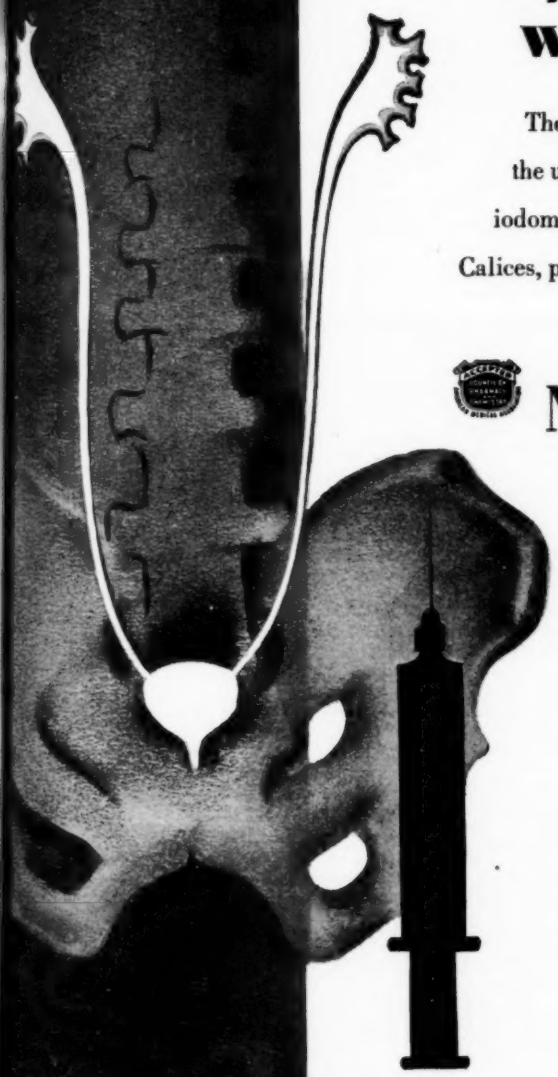
In this life, he was unveeringly honest and frank with himself. Being of this sort, he was without pretense and the counterfeits characteristic of so many of those who live by expedients and stratagems. Yes, we shall miss his friendship. At this time of parting we pause . . . . and think.

How far we of the medical profession could go in meeting the challenges which confront us in this era of social unrest if each one would so order his ways



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of life that at the time of demise all who have received care at our hands would say, "I have lost a friend".

Have we modern doctors in the zeal for better methods lost the human touch of friendship for those we serve? Meeting the financial obligations incident to medical care is often as much of a problem to the patient as recovery of health itself. If we turn an intellectual "blind spot" upon this phase of the patient's life, we may be fulfilling our duty as doctors, but we fall short of being "a friend".

The whole modern world needs something—more friendship perhaps. We're sure a little friendship added to the science of medicine would give it that soul and public good will which it had in the days of our horse-and-buggy grandfathers. — United Medical Bulletin, October 1947.

(Reprinted from New York State Journal of Medicine, December 1, 1947)

NEWS ITEMS

Dr. Keitt H. Smith of Greenville has been appointed by Governor Thurmond to the executive committee of the State Board of Health for a term ending in May 1949.

Dr. Robert B. Taft of Charleston, recently attended the annual meeting of the Radiological Society of North America in Boston. Dr. Taft presented a paper on "Radiation Treatment of Birthmarks".

Dr. W. Thomas Brookman, county publicity chairman, announces the addition of the following members to the Greenville County Medical Society: Dr. W. T. Martin, Dr. Cecil White, Dr. John W. Boling, Dr. W. A. Derrick and Dr. Peggy Fisher, all of Greenville, Dr. Andrew J. Causey, Greer, and Dr. Morgan Milford, Simpsonville.

Dr. Charles P. Corn of Greenville, recently attended the sixth annual meeting of the American Academy of Dermatology in Chicago.

At the annual meeting of the Southern Medical Association in Baltimore in November, Dr. W. Thomas Brockman of Greenville was named chairman of the section on proctology. Congratulations to Dr. Brockman are in order, for this is indeed a high honor.

Dr. Walter E. Bryant of Darlington has opened an office in Darlington for the general practice of medicine. For the past two years Dr. Bryant has been a member of the medical staff of the Johnson Memorial hospital in Hemingway.

Dr. Frank W. Chandler, Jr. of Sumter was married to Miss Louriene Mae Crawford of Kingstree on November 29th at the Kingstree Methodist Church. Dr. Crawford is a graduate of the Medical College of South Carolina and is at present interning at Louisville, Ky.

Dr. J. F. Wood has resigned from service with the government to enter general private practice with Dr. I. D. Durham in West Columbia. Dr. Wood served with the Veterans Administration for sixteen years, having been chief medical officer at the Veterans hospital in Fayetteville before resigning.

Dr. William P. McDaniel has begun the general practice of medicine in Walterboro, with offices at the EsDorn-Stokes Memorial Clinic.

Dr. Harry F. Wilson, Director, Division of Industrial Health, South Carolina Board of Health, was on active duty at the Oliver General Hospital, Augusta, Ga., during the first fifteen days in November. He is a Colonel in the Army Medical Corps Reserve and Commanding Officer of the 396th Evacuation Hospital which is a Reserve Unit.

Dr. A. M. Rubinowitz has recently been certified by the American Board of Dermatology and Syphilology. Dr. Rubinowitz is associated with Dr. J. R. Allison at 1724 Gervais St., Columbia.

Dr. William Russell Jones, Jr., recently joined the staff of Veterans Administration Hospital in Columbia.

Dr. and Mrs. C. Tucker Weston, Jr., announce the arrival of a baby girl on October 29th, at the Columbia Hospital.

Dr. and Mrs. David Wilson, Greenville, announce the birth of a daughter on November 9th.

Dr. David Reese, Greenville, has received a Bronze Star medal for exemplary conduct with an infantry regiment while serving in the campaign in Normandy.

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500 ATTEND ANNUAL MEETING IN COLUMBIA

Approximately 500 doctors, dentists, nurses, sanitarians, health educators, technicians, and clerical workers registered at the annual meeting of the personnel of the State Board of Health and County Health Departments held in Columbia December 9 and 10.

The program of the two-day session, which opened at 10 o'clock Tuesday morning with Dr. Ben F. Wyman, State Health Officer, presiding, included the invocation by the Rev. J. O. Kempson, Chaplain of the S. C. State Hospital; an address by Governor J. Strom Thurmond; remarks by Dr. Wyman; and, with Dr. H. Grady Callison, Director of the Division of Local Health Services, presiding, discussions of programs and future plans of various divisions by their directors. Speakers included Col. Wm. H. Moncrief, S. C. Sanatorium; Dr. Hilla Sheriff, Division of MCH; Dr. G. S. T. Peeples, Divisions of Crippled Children and Cancer Control; Dr. G. A. Bunch, Division of Dental Health; Mr. J. H. Stephens, Division of Sanitary Engineering; Dr. John M. Preston, Division of

Tuberculosis Control; Dr. G. E. McDaniel, Division of Preventable Diseases; Dr. R. W. Ball, Division of VD Control; and Dr. Harry F. Wilson, Divisions of Industrial Health and Laboratories.

During the afternoon, sectional meetings were held with leaders as follows: Health Directors, Dr. Leon Banov; Public Health Nurses, Miss Ellie C. Nelson; Sanitarians, W. P. Boylston; Public Health Educators, W. Gordon Bunch; Clerical Workers, Mrs. Mary B. MacFarlane.

Tuesday evening from 7 to 12, the S. C. Association of Sanitarians gave an informal get-together party in the Rathskeller of the Jefferson Hotel. All who attended the meeting were cordially invited. Dancing and delicious refreshments were enjoyed.

The program Wednesday morning included reports on resolutions made at the sectional meetings; a talk on "South Carolina's Hospital Program" by Dr. C. L. Guyton, Director of the Hospital Division; closing remarks by Dr. Wyman and Dr. Callison; and the motion picture "Making Good Food Better".

Governor Thurmond

In his address, Governor Thurmond strongly advocated a course in health education in South Carolina's schools comparable to the courses now offered in English, Latin and history.

Pointing to the need for more health education, the governor cited his own ignorance of essential health information. "Not until about three months ago," he said, "did I learn how to brush my teeth properly." He commended the State Board of Health for its splendid dental health program in the elementary schools, but added that between 90 and 95 per cent of the children in South Carolina are in need of dental attention.

South Carolina's health, he said, is "near the bottom and the State must have more doctors, dentists, and nurses. Statistics show that in this State there is only one doctor for every 1,659 persons, when the minimum should be one for every 1,000; only one dentist for every 5,500 persons, when the minimum should be one for every 2,000; and only one nurse for every 982 persons, when the national average is one for every 357. Fifteen counties in the State have no hospital facilities."

Deploring the fact that so many young men and women were rejected for military service because of physical defects, Governor Thurmond said that South Carolina ranked fifth highest in the nation in its venereal disease rate, and third highest in infant deaths.

To remedy these unfortunate conditions, he said, "leaders of the State will have to realize the need for supporting health measures. No group can do more than those in public health, and no other state offers a more fertile field for health work."

With reference to research work in health, Governor Thurmond said that he would like to see the federal government appropriate a large sum for that purpose. *"If the leaders in Washington would put as much money into solving the cancer problem as they did to invent the atomic bomb, a cure for the disease would be found."*

Dr. Wyman

Following the Governor's address, Dr. Wyman presented what he called a *"new vision"* of what can be expected in the field of health service.

He explained the recommendations of the S. C. Medical Association for reorganizing the Executive Committee of the State Board of Health.

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Referring to county health work, Dr. Wyman said that a present bill would make available to South Carolina $1,600,000 for special county health programs, but that it would have to be matched with $1,200,000 in State and county funds.

He discussed the possibility of establishing or expanding laboratories in County Health Departments. He said that he expected more money from the federal government for the dental program, and that he believed the legislature would appropriate $150,000 next year for the control of cancer. He urged workers to "*push*" the immunization program, particularly for diptheria, and said he had asked for more money for the malaria control program. Each hospital in South Carolina, he said, will be given a supply of diphtheria anti-toxin for the convenience of doctors over the State.

In his closing remarks before the meeting adjourned on Wednesday, Dr. Wyman commended the clerical workers for having organized, and expressed the hope that advisory councils for the various programs of the State Board of Health would be appointed from the executive committees of the sectional groups—health officers, nurses, sanitarians, health educators and clerical workers. The recommendations made by these groups and adopted by the meeting as a whole, he said, would be presented as information to the Executive Committee of the State Board of Health.

Dr. Guyton

In his talk, Dr. Guyton explained South Carolina's program as provided for under terms of the Hill-Burton Act, which guarantees federal assistance to the State up to $1,975,250 a year for five years for hospital and health center construction.

The money for use in constructing and equipping hospitals and health centers, Dr. Guyton said, will be available only to those communities who will match it two dollars to one. In order to receive the total five year allotment of $9,881,250 it will be necessary for $19,762,500 to be raised in South Carolina.

A hospital advisory council of 25 members was appointed in September, 1947 by Governor Thurmond to consult with the sole agency, the State Board of Health, as required by Public Law No. 725 (Hill-Burton Act).

Even though certain of the counties are too small to operate a hospital of a size economically feasible, Dr. Guyton said, the State Board of Health and the advisory council hopes for every county to receive its fair allocation of beds. Each county then may decide if it wishes to construct and operate its own facilities, or join with some other county or counties in providing for its hospital needs.

The state agency plans to offer assistance to any county in studying the type of hospital facilities it needs. Several of the rural areas will be encouraged to enlarge their hospital facilities so that they may become an intermediate area, serving as a district hospital for the territory in which each is located.

CORRESPONDENCE

December 12, 1947

Dr. Julian P. Price, Secretary
South Carolina Medical Association
105 Cheves Street
Florence, South Carolina

Dear Dr. Price:

The Veterans Administration is attempting to secure information pertaining to physicians in South Carolina who may be entitled to the rating of specialist. Certain standard qualifications for specialist rating have been set up by the Veterans Administration, and it is especially desired by the Branch Medical Director that an opportunity be given to the physicians in this state to submit their applications for consideration.

The following standards for medical specialists performing Out-patient examination or treatment services on a fee basis under State-wide plans are promulgated by Veterans Administration Central Office Professional Services. These standards are for the guidance of Branch Section Chiefs in their recommendations to Branch Medical Directors for selection of specialists to function under State-wide contracts or agreements from lists of physicians proposed as specialists by State Medical Societies. Exceptional or meritorious cases of physicians who do not conform to the standards stated above will be referred for final decision to the Professional Standards Board in Central Office:

1. Those physicians who have been certified by the appropriate Specialty Board should advise this office of the Specialty Boards from which they have received certification.
2. Specialists not possessing Specialty Board certificates—
   (a) At least four years experience in a given specialty, including recognized residency, and
   (b) At least 50% of practice devoted to a given specialty, and
   (c) Recognized as specialists by the Medical Association or Society in the state in which he practices.

It will be very much appreciated if you could give us space in the next issue of your journal advising physicians who desire to be classed as specialists under the above criteria to submit their statements in the form of letters to the Chief Medical Officer, Veterans Administration Regional Office, Fort Jackson, S. C. Your cooperation in this matter will be very much appreciated.

Very truly yours,
D. B. WILLIAMS, M. D.
Chief Medical Officer

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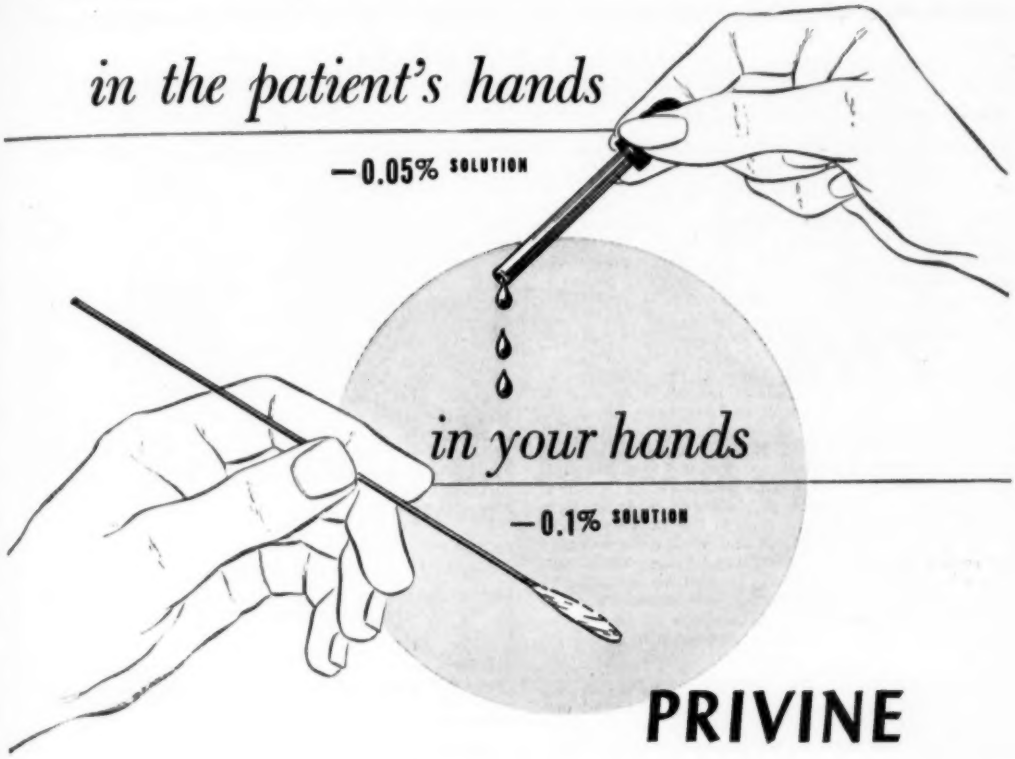

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SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. D. F. Adcock, Columbia, S. C. Publicity Secretary: Mrs. Kirby D. Shealy, Columbia, S. C

A TRIBUTE

The Woman's Auxiliary mourns the passing of Dr. James McLeod. Lingering is the memory of a full and active life too soon ended. The rich rewards of achievement belong to this man who was a once skillful surgeon, loyal soldier, patriotic citizen leader and sympathetic friend to all who knew and loved him. Possessed of an indomitable will, a forthright approach to that which challenged his attention, Dr. McLeod's achievements are those of a realist. Yet with him he carried the spirit of a visionary. He could see that in the future to which many of us have been blind. He envisioned the passing of our democratic form of medical practice with its attendant evils of bureaucracy and socialism. Aware of the potential strength and influence of the Woman's Auxiliary, he was first among those in our state to challenge us to prepare for service to a profession dear to the hearts of each of us, His was a clarion call and with it he brought the encouragement and the financial support of our parent body that was needed. To him we are grateful for recognizing our potentialities, and should the need arise, let us not fall short of his dreams for us nor the opportunity to serve that great profession of which he was one.

Yes, we mourn with others the passing of a fine and good man in the early autumn of his days, and our hearts go out in deepest sympathy to his bereaved family, but within the inmost recesses of our minds we mourn the loss to our Auxiliary of a friend.

COASTAL AUXILIARY ORGANIZED

On November 13 a group of women met for a Dutch dinner at the Twnikling Star Tea Room in Walterboro for the purpose of organizing the Woman's Auxiliary to the Coastal Medical Society, composed of Colleton, Jasper, Dorchester, Berkley, and Beaufort Counties. Mrs. David F. Adcock and Mrs. Aldred F. Burnside of Columbia, president and first vice-president of the state Auxiliary, were there to help with the organization, also Mrs. Robert S. Gantt and Mrs. I. Ripon Wilson of Charleston, councillor for District 1 and first vice-president of the Charleston Auxiliary. Officers elected for the newly organized Auxiliary were Mrs. C. B. Woods, president, Mrs. J. W. Chapman, secretary, and Mrs. C. G. Chapman, treasurer, all of Walterboro.

MRS. ADCOCK HONOR GUEST AT MEMBERSHIP LUNCHEON IN SPARTANBURG

Mrs. David F. Adcock of Columbia, president of the Woman's Auxiliary to the South Carolina Medical Association, was honor guest at a membership luncheon of the Spartanburg Woman's Auxiliary on October 28 at the Peidmont Club. Mrs. Adcock outlined plans for the year, emphasizing the national project of recruiting nurses for training in all hospitals. Mrs. John Watkins, president, presided over the luncheon. Mrs. W. H. Folk gave the invocation. Mrs. L. E. Madden of Columbia, state public relations chairman, was recognized as a guest. Those attending were Mrs. P. M. Temples, Mrs. Furman Wallace, Mrs. J. A. Workman, Mrs. C. B. Hanna, Mrs. W. T. Hendrix, Mrs. Pearson, Mrs. Woodruff, and Mrs. McCord of Woodruff, Mrs. Dennis Hill, Mrs. Leon Poole, Mrs. William H. Folk, Mrs. Earle Poole, Mrs. W. C. Herbert, Jr., Mrs. George Price, Jr., Mrs. J. C. Josey, Mrs. G. D. Johnson, Mrs. Charles Poole, Mrs. E. M. Colvin, Mrs. W. H. Coopman, Mrs. Jesse O. Wilson, Mrs. Edward Law, Mrs. D. C. Alford, Mrs. J. W. Allen, Mrs. B. L. Allen, Mrs. A. K. Temples, Mrs. William Cochran, Mrs. John O. Watkins, Mrs. John Flemming, Mrs. Ed Cochran, Mrs. Clough Wallace, Mrs. Robert Leonard, Mrs. Sam Black, Jr., Mrs. Robert Crow, Mrs. J. D. Nelson, Mrs. W. P. Coan, Mrs. W. A. Wallace, Mrs. Claude Finney, Mrs. Ruskin Anderson, Mrs. J. T. Carter, Mrs. Lesesne Smith, Mrs. Jeanes and Mrs. Flynn of Lyman, and Mrs. John Shirley.

The November meeting of the York County Medical Auxiliary took the form of a Dutch luncheon held in the private dining room of the Andrew Jackson Hotel.

Covers were laid for 21 guests and visitors at a long table decorated in yellow and gold. The place of each guest was marked with a minature corsage of yellow and gold.

Mrs. Roderick Macdonald, president, was in the chair and Mrs. Frank Gaston, program chairman, presented an interesting panel discussion on medical bills now pending in Congress. Taking part were Mrs. Rufus Bratton who talked of the Blue Cross plan, Mrs. J. L. Bundy who discussed the Wagner-Murray-Dingle Bill and Mrs. W. W. Fennell, Jr., whose subject was the Taft Bill.

During the business session reports were heard from Mrs. Frank Gaston, treasurer, Mrs. Gaston Quantz, secretary, and Mrs. Frank Strait, vice-president.

Mrs. Strait reported that the York County Medical Auxiliary last year received the Jane Todd Crawford Memorial Bed and will present it to the York County Hospital.

Plans were also made for assisting the nurses at York County Hospital with their annual Chirstmas dance.

Special guests were Mrs. W. C. Whitesides and Mrs. E. E. Strong both of York.

Mrs. Charles Mims was hostess to a most interesting and important meeting of the Auxiliary to the Greenville County Medical Society at her home on Hillcrest Drive when Mrs. Paul H. Leonard of Columbia, state director of the Field Army of the American Cancer Society, and R. W. Hudgens, national head, were speakers on the work of the organization.

Mrs. J. W. McLean, president of the Auxiliary, was in the chair, and assisting Mrs. Mims in entertaining were Mrs. M. Nachman and Mrs. H. M. Whitworth, Jr.

A large number of members were present for the meeting.

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SURGERY—Intensive Course in Surgical Technique, Two Weeks, Starting January 19, February 16, March 15.
Surgical Technique, Surgical Anatomy & Clinical Surgery, Four Weeks, Starting February 2, March 1, March 29.
Surgical Anatomy & Clinical Surgery, Two Weeks, Starting February 16, March 15.
Surgery of Colon & Rectum, One Week, Starting March 8, April 26.
Surgical Pathology Every Two Weeks.
FRACTURES & TRAUMATIC SURGERY—Intensive Course, Two Weeks, Starting April 26.
GYNECOLOGY—Intensive Course, Two Weeks, Starting February 23, March 29.
Personal Course in Vaginal Surgery Starting February 16, March 22.
OBSTETRICS—Intensive Course, Two Weeks, Starting March 15, April 12.
MEDICINE—Intensive Course, Two Weeks, Starting April 26.
Personal Course in Gastroscopy, Two Weeks, Starting March 29, April 19.
Electrocardiography & Heart Disease, Four Weeks, Starting February 16, May 3.
CYSTOSCOPY—Ten Day Course Starting January 5, January 19, February 2.
DERMATOLOGY—Formal Course, Two Weeks Starting April 26.
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